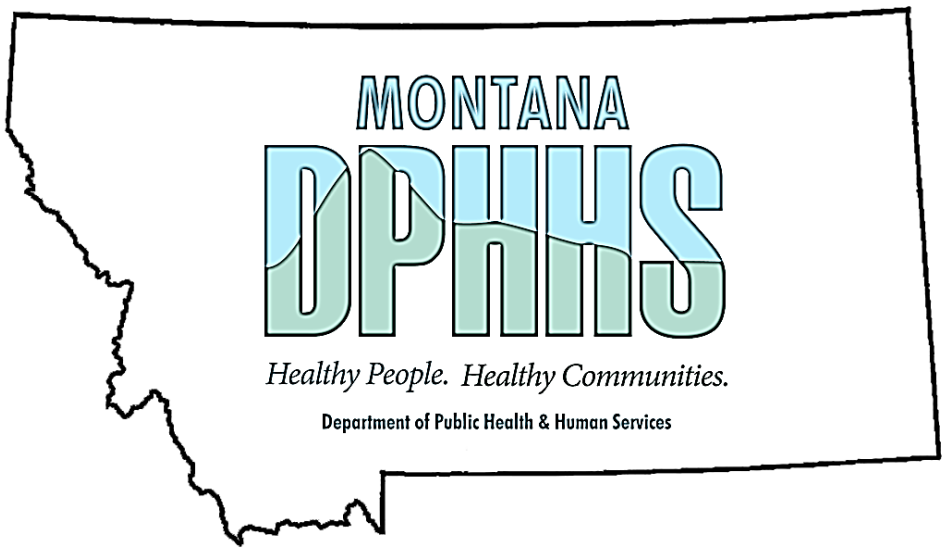
The Montana Medicaid Program



Montana Department of Public Health and Human Services Report to the 2017 Legislature

State Fiscal Years 2015/2016

January 9, 2017

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Dear Legislators:

The Department of Public Health and Human Services (DPHHS) is pleased to provide the Montana Medicaid Program Report to the 2017 Legislature, as is required by 53-6-110 Montana Code Annotated. This report provides insight into Montana's Medicaid Program and its multiple activities and numerous accomplishments.

Medicaid is a joint federal-state program that pays for a broad range of medically necessary health care services for low income populations. DPHHS administers the program in partnership with the federal Centers for Medicare and Medicaid Services (CMS).

Medicaid reimbursed over $1 billion dollars in SFY 2015. Most of these funds were spent in Montana and went to private providers. Not only do these funds contribute to the Montana economy, Medicaid funding helps assure access to services in rural and frontier areas of our state. Medicaid is the primary (and often the only) payment source for long term care services for the elderly and people with an intellectual disability or a serious mental illness.

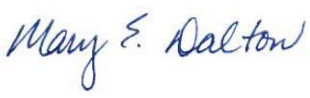
Montana Medicaid is the state's largest public/private health care coverage program. Since the 2015 Legislature expanded the program through the Health and Economic Livelihood Partnership (HELP) Act, it now touches the lives of approximately 20% of Montanans. Prior to the HELP Act, Medicaid health coverage was limited to children, pregnant women, very poor parents of children, the elderly, and people with disabilities. Now, coverage is also available to adults between the ages of 19-64 with incomes at or below 138% of Federal Poverty Level.

This report provides a basic explanation of Medicaid eligibility; benefits; waivers; cost containment and cost avoidance measures; interactions with other payment sources; and rate setting methodologies for the "non-expansion" population. It also provides an overview of projected expenditures for SFYs 2016 and 2017.

A separate report presented to the HELP Act Oversight Committee in July 2016 is devoted to the details of the HELP Plan (Medicaid expansion).

I hope that you find this report useful. If you have any questions, or if we can provide additional information, please contact me at (406) 444-4084 or mdalton@mt.gov. This report is also available on our website at dphhs.mt.gov.

Sincerely,



Mary E. Dalton / Montana State Medicaid Director

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The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program.

Program Mission:

Assure necessary medical care is available to all eligible Montanans within available funding resources.

Goals:

- Improve health outcomes by emphasizing primary care, improving access to services for underserved and vulnerable populations, promoting appropriate utilization of preventive and other necessary services, and reducing the number of uninsured people.
- Provide community-based services as an alternative to institutional care.
- Ensure cost effectiveness in the delivery of health care services by using efficient management practices and maximizing revenue opportunities.
- Assure the integrity and accountability of the Medicaid health care delivery system.
- Implement measures that will constrain the growth in Medicaid expenditures while improving services.

Medicaid Program Overview

The Montana Medicaid program is a joint federal-state program. DPHHS administers the program in partnership with the federal Centers for Medicare and Medicaid Services (CMS). States are required to provide the same amount, duration, and scope of services to all people who receive a Medicaid benefit unless they have a waiver. DPHHS is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. As a general rule, the Montana Medicaid program has flexibility within certain guidelines established by CMS to: 1) design our own eligibility package; 2) design our own benefit package; and 3) determine provider reimbursement.

Medicaid services are funded by a combination of federal and state (and in some situations, local) funds. In Montana, the matching rate is approximately 65% federal and 35% state funds. Simply stated, if DPHHS receives 35 cents in general funds, the 35 cents becomes a Medicaid dollar. Some Medicaid services receive an enhanced federal match rate such as: services provided by Tribal Health Services at 100% federal dollars; family planning services at 90% federal; and services through the breast and cervical cancer program at 76%. In addition, administrative costs of the State are matched at 50% and data systems are matched at 75%.

Medicaid Eligibility

The rules governing Medicaid eligibility changed with the passage of the Affordable Care Act. As of March 2010, a state is ineligible for federal payments if it decreases eligibility for Medicaid below the level in place as of that date. Montana can still choose to add eligibility categories but we cannot decrease either the number of categories/groups that we cover nor can we decrease the level of poverty for existing coverage groups.

The following are the existing groups /populations for whom Montana provides Medicaid coverage.

Children – Healthy Montana Kids (HMK) is the largest provider of health care coverage for children in the State of Montana. HMK covers children through Medicaid and CHIP funding. The Medicaid portion of this program is Healthy Montana Kids *Plus* and during SFY 2014, an average of 81,128 children enrolled in Medicaid per month. In 2015, an average of 86,269 children were enrolled.

The Children's Health Insurance Program portion of this program is Healthy Montana Kids. During SFY 2014, an average of 23,371 children were enrolled each month. In 2015, an average of 19,919 children were covered each month.

Children are covered by Medicaid under one of the following three programs:

- **Healthy Montana Kids *Plus*** - Children up to the age of 19 in families with countable income equal to or less than 143% of the Federal Poverty Level (FPL).

- **Infants** - Children born to women who receive Medicaid at the time of their birth automatically qualify for Medicaid coverage through the month of their first birthday.

- **Subsidized Adoption, Subsidized Guardianship and Foster Care** – Children, eligible for an adoption or guardianship subsidy through DPHHS, are automatically eligible for Medicaid coverage. This coverage may continue through the month of the child's 21st birthday. Children, placed into licensed foster care homes by the Child and Family Services Division, are also Medicaid eligible.

Pregnant Women – Medicaid is provided to eligible pregnant women with countable income equal to or less than 157% FPL. The coverage extends for 60 days beyond the child's birth.

2016 Federal Poverty Levels & Gross Monthly Income

Family Size	Pregnant Woman 157% FPL	HMK 261% FPL	Child or HMK Plus 143% FPL
1	$1,554	$2,584	$1,416
2	$2,096	$3,484	$1,909
3	$2,638	$4,385	$2,402
4	$3,179	$5,285	$2,896
Resource Test	No Test	No Test	No Test

Families with Dependent Children – Parents or related caretakers (grandparents, aunts/uncles, etc.) whose countable income is below the Family Medicaid income level (approximately 24 % FPL or $486/month earnings for family of four) may receive Medicaid. Temporary Assistance for Needy Families (TANF) cash assistance eligibility is determined separately from Medicaid.

Aged - Individuals, age 65 or older, may be eligible for Medicaid if their countable income is within allowable guidelines and their resources do not exceed $2000 for an individual or $3000 for a couple.

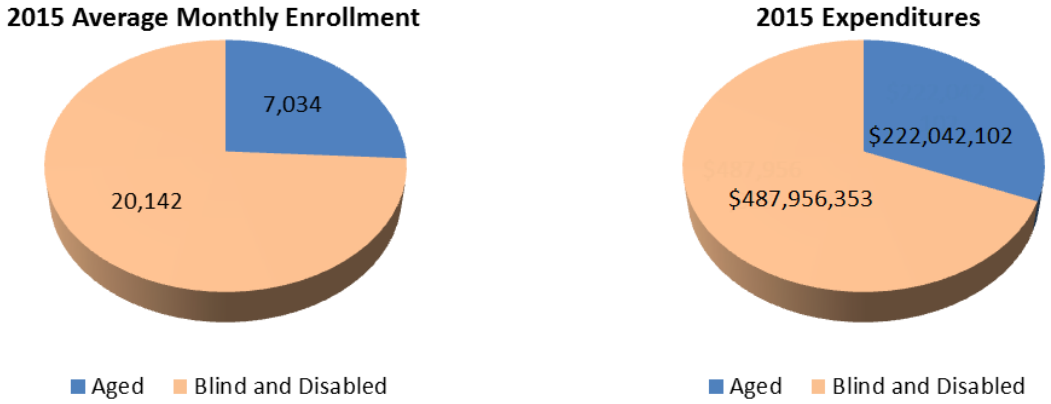
Blind/Disabled – Individuals may be eligible for Medicaid if determined blind or disabled using Social Security criteria, and if their income is within allowable limits and their resources do not exceed $2000 for an individual or $3000 for a couple. Income limits for the Aged, Blind, Disabled programs are $733 per month for an individual and $1100 for a couple.

People Who Are Aged, Blind, or Disabled and Receive Supplemental Security Income (SSI) - In Montana, under an agreement with the Social Security Administration, any individual determined eligible for SSI receives Medicaid. These individuals with low income are aged, blind, or disabled and make up a large group within the Medicaid program. Many of these clients live alone and struggle to maintain independence due to health conditions requiring regular medical attention. New SSI monthly income standards for 2016 are $733 per month for an individual and $1,100 for a couple.

2016

Family Size	Resource Limit	Monthly SSI Income Limit
1	$2,000	$733
2	$3,000	$1,100

Enrollment and Expenditure Comparison Aged and Blind / Disabled



Note that graphs above do not include HMK (CHIP), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

Breast and Cervical Cancer Treatment - This program is for women diagnosed with cancer or pre-cancerous conditions of the breast or cervix. An eligible woman must be under 65 years old, not have insurance considered to be 'creditable coverage,' meet citizenship or qualified alien requirements, be a Montana resident, and have been screened through the Montana Breast and Cervical Health Program. Countable income cannot exceed 250% of the FPL and there is no resource test.

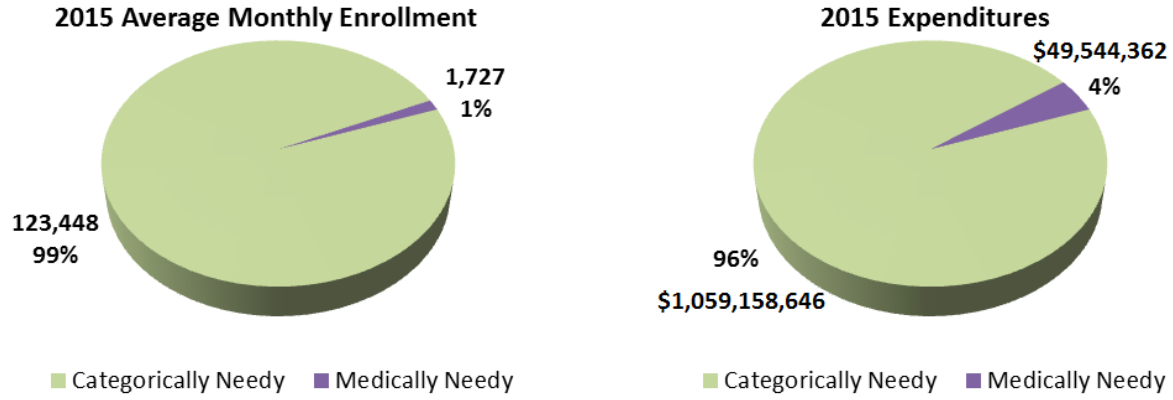
Montana Medicaid for Workers with Disabilities (MWD) – Montana implemented MWD effective July 1, 2010. MWD allows certain individuals who meet Social Security's disability criteria to receive Medicaid benefits through a cost share. The cost share is based on a sliding scale according to an individual's income. Individuals must be employed (either through an employer or self-employed) to be considered for this program. MWD resource and income standards are significantly higher than many other Medicaid programs: $15,000 for an individual and $30,000 for a couple; while the countable income limit is 250% of the FPL.

Medically Needy – This is coverage for the aged, blind, disabled, pregnant women, and children whose income exceeds the Categorically Needy income standards for these coverage programs, but who have significant medical expenses. Spend down works a lot like a deductible in insurance where the individual/family is responsible for a certain amount before medical bills are covered. The individual or family becomes Medicaid-eligible by making a cash payment for the spend down amount, incurring medical bills equal to the amount of the spend down, or combining a monthly cash payment with existing medical bills. The resource limit is $2000 for an individual, and $3000 for a couple or family. Countable income is reduced by earned income deductions, a $100 general income disregard, and a $100 medically needy income deduction.

State Fiscal Year 2016 Limits for Medically Needy

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000**	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
**$2,000 for aged, blind, or disabled individuals, $3,000 for children, pregnant women and for aged, blind, or disabled couples.		

Comparison between Categorically Needy and Medically Needy



Note that graphs above do not include HMK (CHIP), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

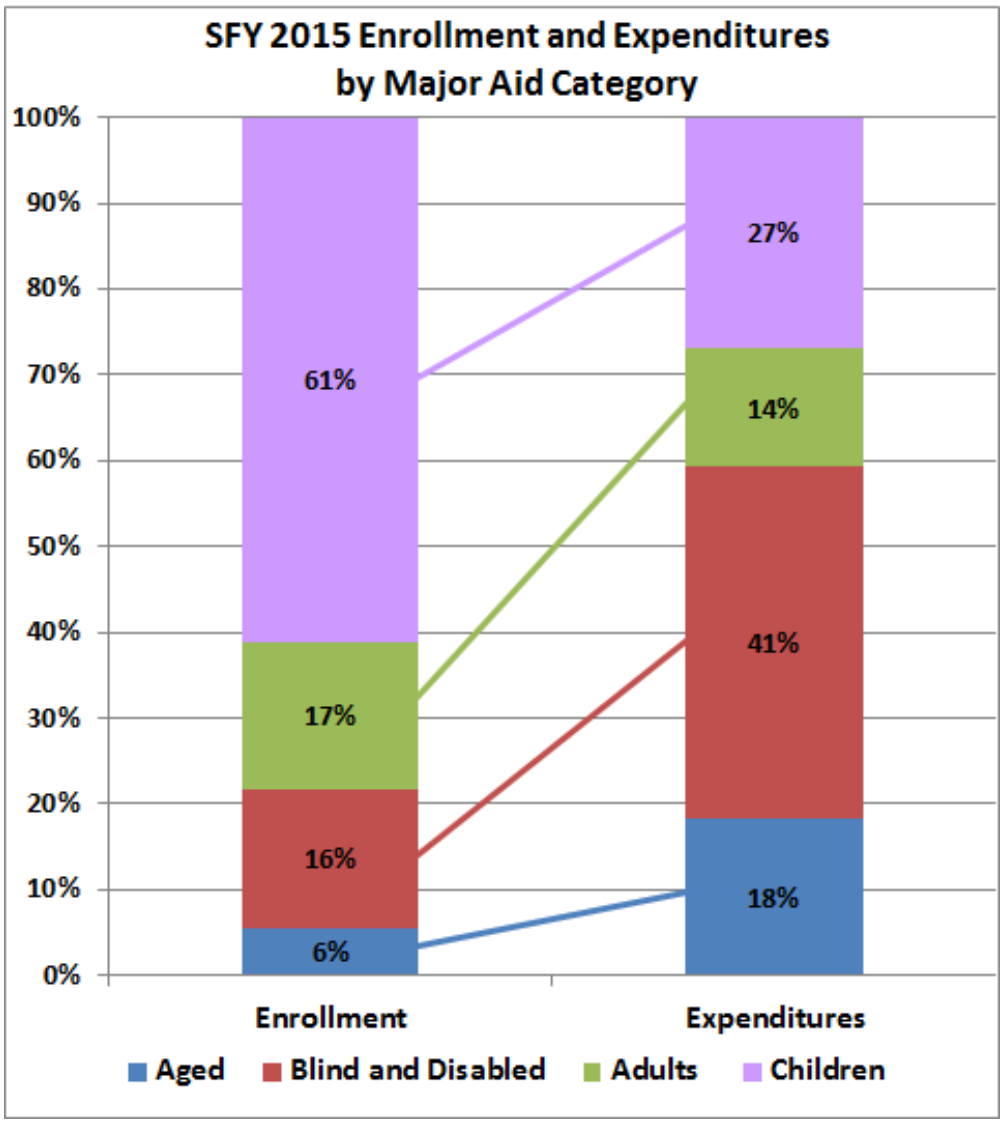
Summary of Medicaid Enrolled Persons for State Fiscal Year 2015

Beneficiary Characteristic	Average Monthly Enrollment All	Aged	Blind & Disabled	Adults	Children	% of Medicaid Total	% of Montana Population
Total	**125,177**	**7,034**	**20,142**	**21,486**	**76,515**	**100%**	
Age							
0 to 1	6,614	0	33	0	6,581	5%	2%
1 to 5	26,253	0	494	0	25,760	21%	5%
6 to 18	46,671	0	2,496	0	44,174	37%	17%
19 to 20	1,785	0	477	1,308	0	1%	2%
21 to 64	36,530	0	16,353	20,178	0	29%	58%
65 and older	7,323	7,034	289	0	0	6%	16%
	125,177	7,034	20,142	21,486	76,515		
Gender							
Male	56,261	2,232	10,066	5,242	38,721	45%	50%
Female	68,916	4,802	10,076	16,244	37,795	55%	50%
	125,177	7,034	20,142	21,486	76,515		
Race							
White	87,660	5,843	16,034	14,843	50,940	70%	93%
Native American	26,206	759	3,149	4,930	17,368	21%	4%
Other	11,311	432	958	1,714	8,207	9%	3%
	125,177	7,034	20,142	21,486	76,515		
Assistance Status*							
Medically Needy	1,728	832	867	4	25	1%	
Categorically Needy	123,449	6,202	19,275	21,483	76,489	99%	
	125,177	7,034	20,142	21,486	76,515		
Medicare Status							
Part A and B	15,241	6,578	7,884	779	1	13%	
Part A only	77	16	37	24	0	0%	
Part B only	429	417	12	0	0	0%	
None	109,430	24	12,209	20,683	76,514	87%	
	125,177	7,034	20,142	21,486	76,515		
Medicare Saving Plan (not included in total)							
QMB Only	4,912	2,357	2,555	0	0		
SLMB - QI Only	4,422	4,422	0	0	0		
Other Medicaid Eligibles (not included in total)							
HK Exp (CHIP Funded)	8,314	0	0	7	8,307		
Plan First Waiver	2,260	0	0	2,260	0		

* Medically Needy clients are responsible for their medical bills each month until they have incurred enough medical expenses equal to the difference between their countable income and the Medically Needy income level.

Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees Medicaid pays for Medicare premiums, co-insurance, and deductibles. For SLMB - QI only enrollees Medicaid pays for Medicare Premiums.

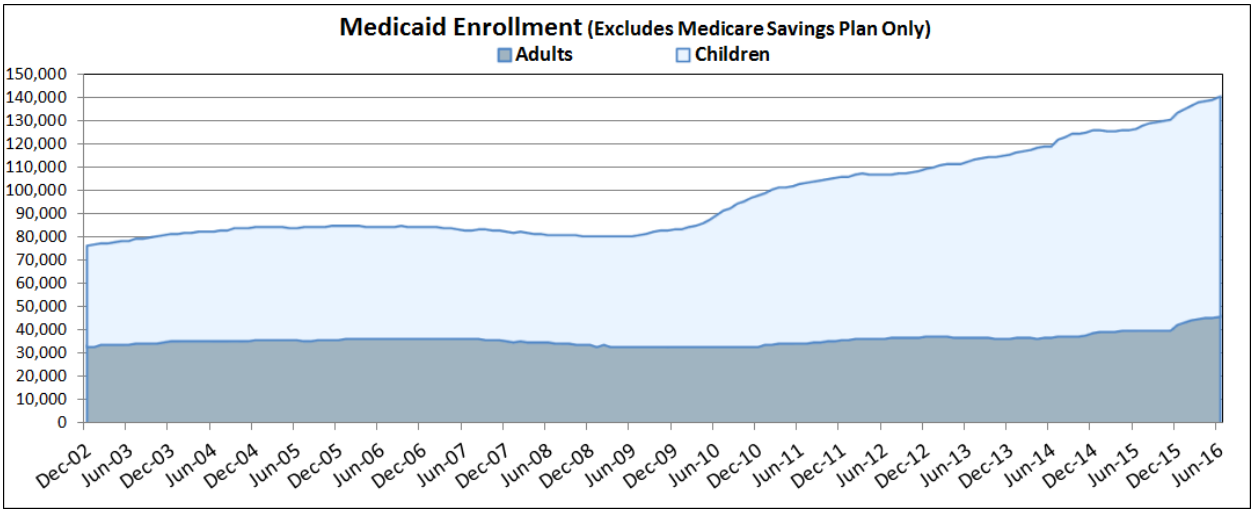
The column in the above chart "% of Montana Population" shows the percentage of Montana population for that beneficiary characteristic. For example, 50% of Montana's population is female, but 55% of the total Medicaid population in Montana is female.

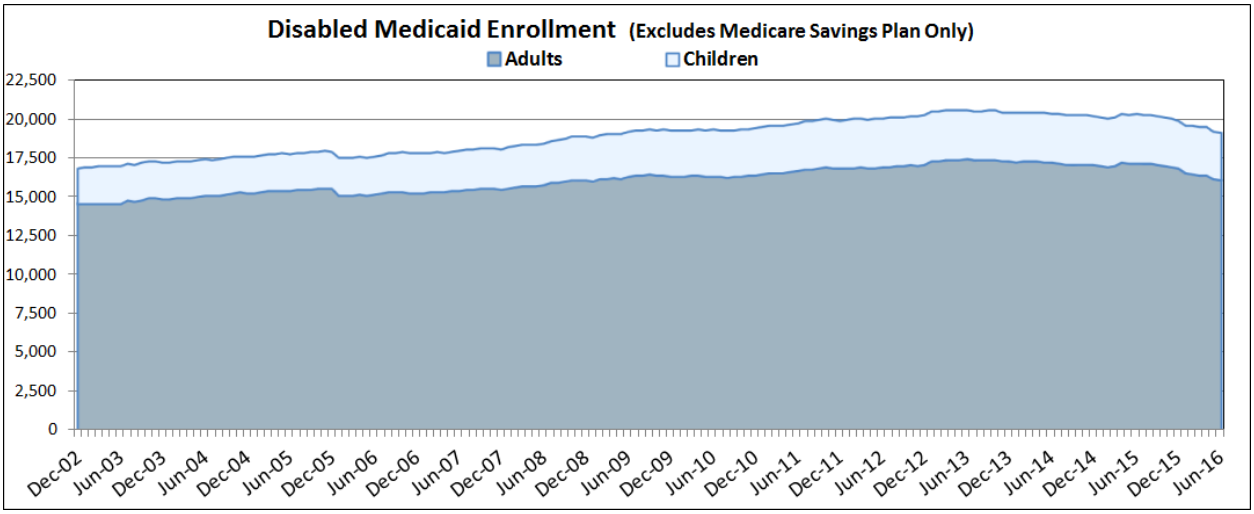


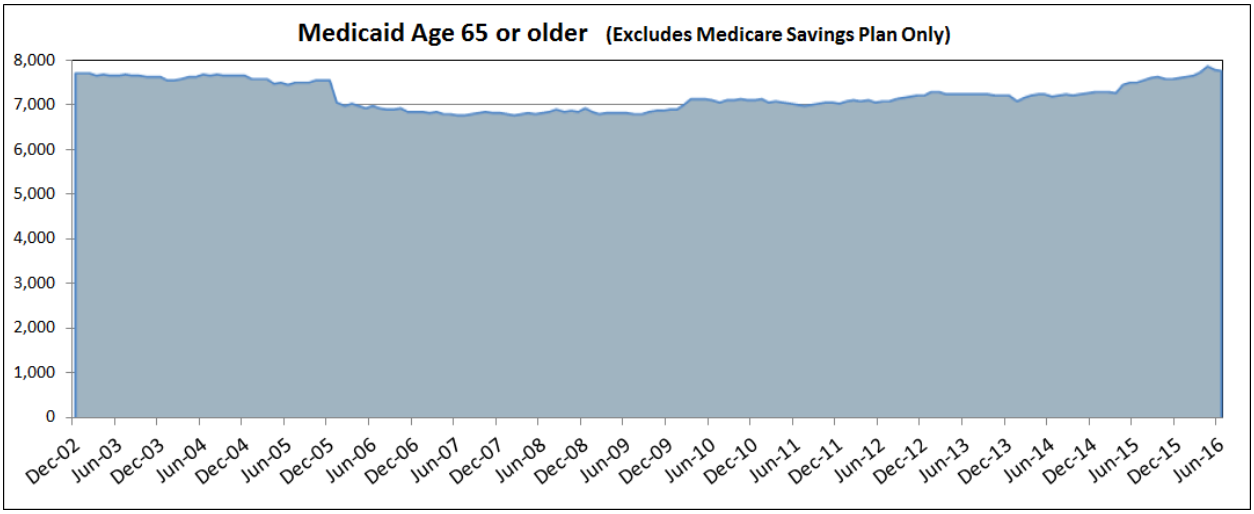
SFY 2015 Enrollment and Expenditures by Major Aid Category

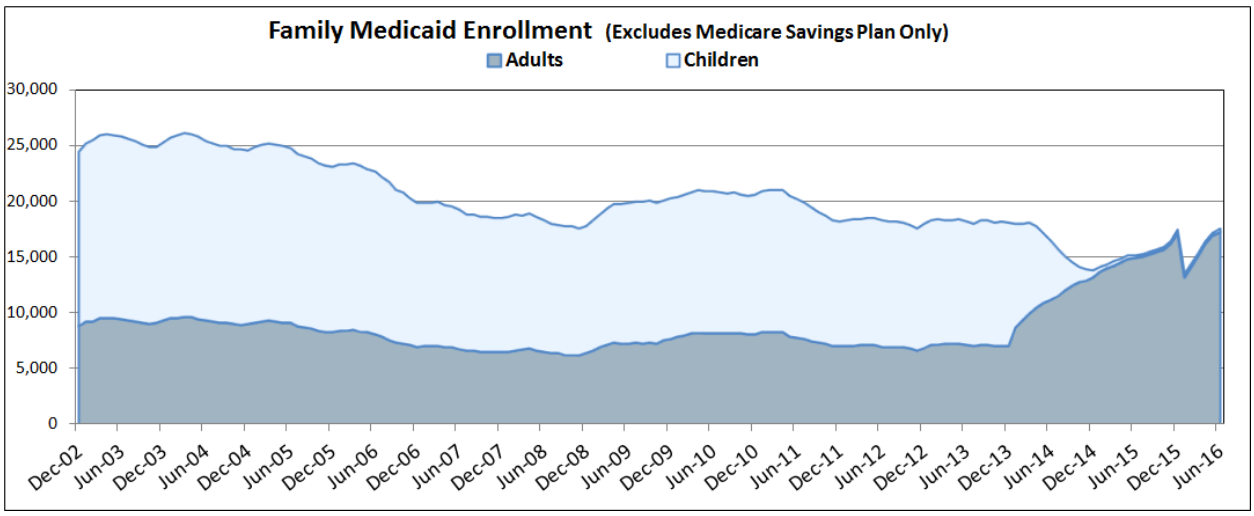
Aid Category	Average Monthly Enrollment	Percent of Enrollment	Expenditures	Percent of Expenditures
Aged	7,034	6%	$203,172,599	18%
Blind and Disabled	20,142	16%	$453,527,254	41%
Adults	21,486	17%	$152,883,627	14%
Children	76,515	61%	$299,119,528	27%
Total	125,177	100%	$1,108,703,009	100%

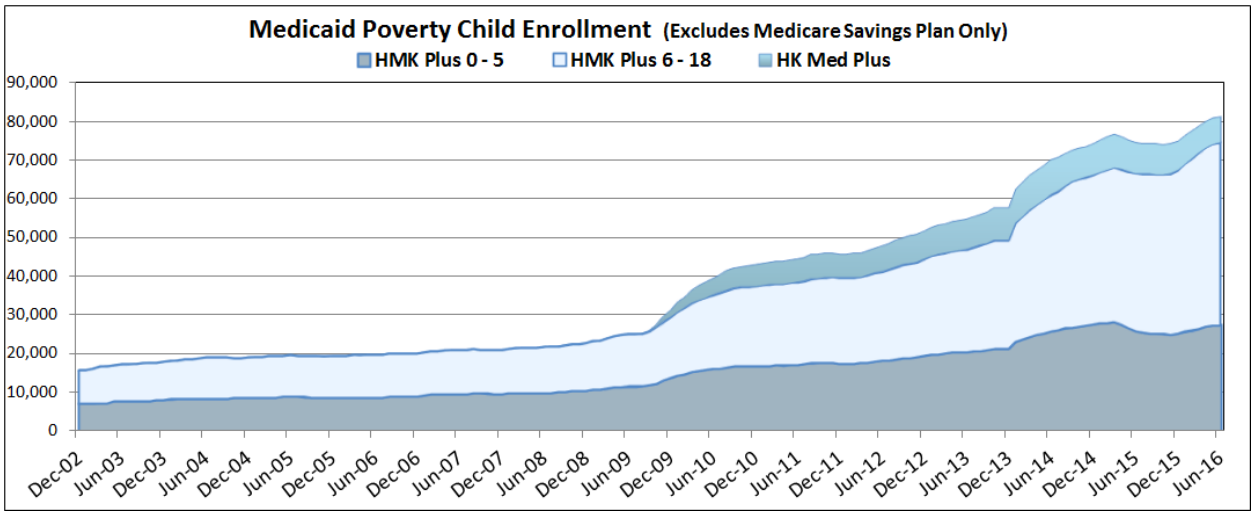
Note that graphs above do not include HMK (CHIP Funded), Medicare Savings Plan, or Plan First Waiver clients and expenditures.

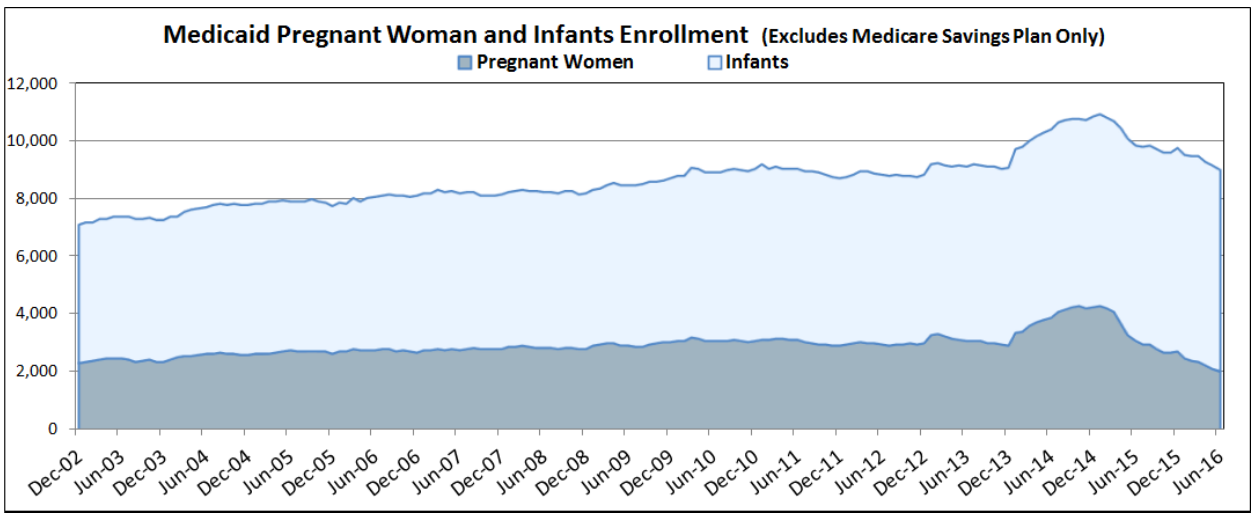

Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
150,000
140,000
130,000
120,000
110,000
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Dec-02 Jun-03 Dec-03 Jun-04 Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09 Jun-10 Dec-10 Jun-11 Dec-11 Jun-12 Dec-12 Jun-13 Dec-13 Jun-14 Dec-14 Jun-15 Dec-15 Jun-16


Disabled Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
22,500
20,000
17,500
15,000
12,500
10,000
7,500
5,000
2,500
0
Dec-02 Jun-03 Dec-03 Jun-04 Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09 Jun-10 Dec-10 Jun-11 Dec-11 Jun-12 Dec-12 Jun-13 Dec-13 Jun-14 Dec-14 Jun-15 Dec-15 Jun-16


Medicaid Age 65 or older (Excludes Medicare Savings Plan Only)
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Dec-02 Jun-03 Dec-03 Jun-04 Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09 Jun-10 Dec-10 Jun-11 Dec-11 Jun-12 Dec-12 Jun-13 Dec-13 Jun-14 Dec-14 Jun-15 Dec-15 Jun-16


Family Medicaid Enrollment (Excludes Medicare Savings Plan Only)
Adults
Children
30,000
25,000
20,000
15,000
10,000
5,000
0
Dec-02 Jun-03 Dec-03 Jun-04 Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09 Jun-10 Dec-10 Jun-11 Dec-11 Jun-12 Dec-12 Jun-13 Dec-13 Jun-14 Dec-14 Jun-15 Dec-15 Jun-16


Medicaid Poverty Child Enrollment (Excludes Medicare Savings Plan Only)
HMK Plus 0 - 5
HMK Plus 6 - 18
HK Med Plus
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Dec-02 Jun-03 Dec-03 Jun-04 Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09 Jun-10 Dec-10 Jun-11 Dec-11 Jun-12 Dec-12 Jun-13 Dec-13 Jun-14 Dec-14 Jun-15 Dec-15 Jun-16


Medicaid Pregnant Woman and Infants Enrollment (Excludes Medicare Savings Plan Only)
Pregnant Women
Infants
12,000
10,000
8,000
6,000
4,000
2,000
0
Dec-02 Jun-03 Dec-03 Jun-04 Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09 Jun-10 Dec-10 Jun-11 Dec-11 Jun-12 Dec-12 Jun-13 Dec-13 Jun-14 Dec-14 Jun-15 Dec-15 Jun-16

Medicaid Benefits

The Montana Medicaid benefits packages meet federal guidelines. Medicaid benefits are divided into two classes. Federal law requires that adults eligible for Medicaid are entitled to the following services unless waived under Section 1115 of the Social Security Act. These are referred to as mandatory services and include:

- Physician & Nurse Practitioner
- Nurse Midwife
- Medical & Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Facility
- Home Health
- Durable Medical Equipment
- Transportation

States may elect to cover other optional services. Montana has chosen to cover a number of other cost-effective optional services* including, but not limited to, the following:

- Outpatient Drugs
- Dental and Denturist Services
- Comprehensive Mental Health Services
- Ambulance
- Physical & Occupational Therapies and Speech Language Pathology
- Home & Community Based Services
- Eyeglasses & Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry
- Community First Choice

*There is an exception to a state's ability to decide which optional services it will cover. Under federal **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** regulations, a state must cover all medically necessary services to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen for individuals under age 21. This is true of whether the service or item is otherwise included in the State Medicaid plan. (The EPSDT benefit is optional for the medically needy population.)

Medicaid Waivers

State Medicaid programs may request from CMS a waiver(s) of certain federal Medicaid requirements that are found in the Social Security Act. A common public misconception is that any portion of the Medicaid program can be waived by CMS. In reality, only certain requirements such as statewideness, freedom of choice, and comparability of eligibility and/or benefits can be waived. Waivers are also limited in that they must always be cost neutral to the federal government.

The following is a brief description of the three types of waivers that Montana operates:

- **Section 1115 waivers** authorize experimental, pilot, or demonstration project(s). The Secretary of Health and Human Services has complete discretion as to whether an 1115 waiver is granted. This kind of waiver is granted only when the Secretary feels that a state will demonstrate something that is of interest in promoting the objectives of the Medicaid program. This waiver can be used to expand eligibility for Medicaid. The number and type of services can either be limited or expanded under this type of waiver.

- **Section 1915(b) waivers** allow States to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice Waivers available:
  (b)(1) to mandate Medicaid enrollment into managed care
  (b)(2) to utilize a "central broker"
  (b)(3) to use cost savings to provide additional services
  (b)(4) to limit the number of providers for services

- **Section 1915(c) waivers** are referred to as Medicaid Home and Community-Based Services (HCBS) waivers. They are alternatives to providing long-term care in an institutional setting (Medicaid defines an institution as a nursing facility, hospital, or Intermediate Care Facility for Individuals with Developmental Disability). A 1915(c) waiver enables a state to pay for an expanded array of medical care and support services that assist people to continue to live in their homes and/or communities. These waivers also allow a state, if it wishes, to count only the income of the affected individual rather than that of the whole family when determining eligibility.

  States often combine waivers to achieve their goals. A 1915(b)/1915(c) or 1115/1915(b) are the most common combinations.

Montana operates a number of different waivers in order to better customize services for key populations. A brief description of our current waivers is found on the next several pages.

1115 Waiver for Additional Services and Populations – Health Resources and Addictive and Mental Disorders Divisions – [Formerly known as the HIFA or Basic Waiver, this waiver has significantly changed over the years.] Approved in 1996, this waiver offered a limited Basic Medicaid benefit package of optional services to 'able-bodied' Medicaid eligible adults, ages 21 to 64. Participants received a basic package of Medicaid benefits that excluded: audiology, dental and denturist, durable medical equipment, eyeglasses, optometry and ophthalmology for routine eye exams, personal care services, home infusion and hearing aids.

In December 2010, the state received approval to use the federal savings generated from able-bodied adults to expand the waiver and cover up to 800 adults who previously qualified for the state-funded Mental Health Services Plan (MHSP), up to 150 percent of the FPL. (This waiver was commonly referred to as the HIFA or MHSP waiver.) For the first time, individuals who had either schizophrenia or bipolar disorder qualified for physical health benefits as well as a more comprehensive mental health benefit.

In January 2014 the waiver expanded twice, ultimately having capacity to cover up to 6,000 individuals with a severe disabling mental illness (SDMI) diagnosis.

In July 2016, the following changes were made to the waiver:

- Able-bodied adults from the waiver were transferred to Standard Medicaid or to the HELP waiver based on income levels;
- Adults with SDMI under the age of 65 were transferred to the Standard Medicaid program;
- Coverage was continued for adults with serious and disabling mental illness between 139-150% FPL. There is continued coverage for adults with serious and disabling mental illness who are eligible for or enrolled in Medicare, and continued coverage for a very small number of adults with serious and disabling mental illness who do not otherwise qualify for Medicaid. Total enrollment for all three of these groups of people with serious and disabling mental illness is capped at 3000 individuals;
- Aligned the Basic Medicaid benefit package with the Standard Medicaid benefit package; and
- Adopted a 12-month continuous eligibility period for all non-expansion Medicaid-covered individuals whose eligibility is based on MAGI.

In December 2016, the name of the waiver was changed to the Section 1115 Montana Waiver for Additional Services and Populations (WASP) and coverage for dental treatment services above the Medicaid State Plan cap of $1,125/individual was added for people determined categorically eligible as Aged, Blind or Disabled.

1115 Plan First Waiver – Health Resources Division – This waiver covers family planning services such as office visits, contraceptive supplies, laboratory services, and testing and treatment of STDs. This waiver provides savings to the state and federal government by avoiding unintended pregnancies. In general, eligibility is open to females ages 19 through 44 (who are able to bear children and not presently pregnant) with an annual household income up to 211% FPL.

This program is limited to 4,000 women at any given time. CMS approved this waiver on May 30, 2012. In 2015, 1,884 women were served at a cost of $1,014,111. This waiver will be renewed in January 2018.

1915(b) Waiver Passport to Health - Health Resources Division – The Passport to Health waiver has four program components. All four components help members access and utilize services appropriately. Care management services offered under the waiver enhance care by minimizing ineffective or inappropriate medical care to Medicaid and HMK *Plus* members. The waiver is operated in all 56 counties and involves about 70 percent of all Montana Medicaid members. The first component, **Passport to Health**, is the primary care case management program in which most Medicaid and HMK *Plus* eligible individuals are enrolled. A member chooses or is assigned a primary care provider who delivers all medical services or furnishes referrals for other medically-necessary care.

The second component is **Team Care**, a program for individuals identified with inappropriate or excessive utilization of health care services, including overutilization of the emergency room. Members are identified for Team Care through referrals from providers, Health Improvement Program care managers, the Drug Utilization Review Board, or through claim review. Individuals are enrolled in Team Care for at least 12 months and are required to receive services from one pharmacy and one medical provider. Approximately 650 Medicaid and HMK *Plus* members are currently enrolled in the Team Care program.

The third component, the **Health Improvement Program,** is an enhanced primary care case management program, administered in partnership with 13 community health centers and the Fort Peck Tribes. The top five percent of high-cost, high-risk Medicaid and HMK *Plus* members are identified by Medicaid through the use of predictive modeling software, provider referrals, and high utilization measures. Care managers and health coaches provide in-person and telephonic health care management services and report quality measures to improve health outcomes. This program increases the ability of members to self-manage their health conditions.

This fourth component is **Nurse First**, a 24/7 Nurse Advice Line available to all Medicaid and HMK *Plus* members. The advice line is operated by a vendor and through clinically-based algorithms directs callers to the most appropriate level of care: self-care, provider visit, or emergency department visit.

Quality, access to care, and health outcomes are continuously monitored, tracked, and reported. Members and providers report satisfaction with these care management programs that document annual cost avoidance to Medicaid.

1915(c) HCBS Children's Autism Waiver - **Developmental Services Division** - CMS approved the waiver on January 1, 2009 to serve Montana children ages 15 months through 7 years old with autism and adaptive behavior deficits. This Children's Autism Waiver (CAW) provides early intervention based upon applied behavioral analysis training models. Children receive up to 20 hours of intensive training per week that is focused on improving skills in the areas of communication, socialization, academics, and activities of daily living while reducing maladaptive behaviors. The waiver serves 60 children per year at an approximate cost of $1.5 million per year. Children may be served for a maximum of three years. Seven agencies across the state provide program design and training, case management services, and other supports to enrolled children and their families.

This waiver is transitioning to a state plan service which will serve more individuals up to age 21 with autism as a state plan approved service. This will allow the DPHHS to serve more children/youth.

1915(c) HCBS 0208 Comprehensive Services Waiver for Individuals with Developmental Disabilities - Developmental Services Division - This waiver for people with Developmental Disabilities (DD) was initiated in 1981. It was the second waiver in the country approved to provide community based services to persons needing DD services. The waiver includes a wide range of services intended to meet an individual's assessed needs as identified in the annual plan of care, such as: waiver children's case management, residential habilitation, employment, respite, retirement services, private duty nursing, environmental modifications/adaptive equipment, and day supports/activities. In SFY 2016, this waiver served 2,657 unduplicated participants. As of August 12, 2016 there were 1,151 individuals on the waiver wait list with an average time on the wait list at 620 days.

1915(c) HCBS Supports for Community Working and Living Waiver - Developmental Services Division – As of October 2015, this waiver was consolidated into the aforementioned Comprehensive waiver.

1915 (c) HCBS The Community Working and Living Waiver - Developmental Services Division - As of October 17, 2015 this waiver was consolidated into the aforementioned Comprehensive waiver. The transition into the Comprehensive Services Waiver improved service options for members and has made program operation and administration more efficient.

1915(b) (4) and 1915(c) The Montana Big Sky Waiver - Senior and Long Term Care Division - This is a concurrent or combination 1915(b)(4) and 1915(c) waiver (see earlier description of Medicaid Waivers). The Big Sky or HCSB Waiver, serving the elderly (age 65 and older) and people with physical disabilities, started in 1982. The program recognizes that many individuals at risk of being placed in institutional settings can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care. To qualify a person must be financially eligible for Medicaid and meet the program's level of care requirements in a nursing facility or hospital. DPHHS contracts with case management teams to develop an individual plan of care in conjunction with the consumer. This waiver has an extensive menu of services which includes case management, respite, adult residential care, specialized services for those with traumatic brain injuries, environmental modifications, health and wellness, consumer directed services and personal emergency response systems. On July 01, 2011, Montana added the 1915 (b) component, which limits the number of case management teams available. In SFY 2015, more than 2,500 individuals received Montana Big Sky Waiver funded services.

1915(c) HCBS SDMI Waiver - Addictive and Mental Disorders Division - Implemented in December 2006, this waiver allows Medicaid reimbursement for community-based services for individuals who are 18 years of age or older with SDMI who meet criteria for nursing home level of care. The waiver's 298 slots are distributed among seven geographic core areas including Billings, Great Falls, Missoula, Helena, Butte, Kalispell, and Bozeman, plus surrounding counties. (Kalispell and Bozeman were added as sites in 2016.) In each site, services are coordinated by a team that is made up of a registered nurse and a social worker. Services provided to persons enrolled in the SDMI waiver include case management, wellness recovery action plan, illness management and recovery program, non-medical transportation, specialized medical equipment and supplies, personal emergency response, adult day care, respite, private duty nursing, prevocational services, supportive employment, , habilitation aide, substance use related disorders services, residential habilitation, personal assistance and specially trained attendants, environmental accessibility modifications, consultative clinical and therapeutic services, community transition, health and wellness, peer support, and pain and symptom management.

Upcoming Issue - One issue facing all 1115 and 1915 (c) HCBS waivers is a new regulation issued by CMS in March 2014. This regulation, among other things, redefines the characteristics of a home-based setting and may mean that some providers of assisted living facility services may need to change the physical characteristics of their facility if they wish to continue serving waiver clients. DPHHS is working closely with waiver consumers and providers to mitigate the impact of this regulation. DPHHS has been working on a statewide transition plan as part of the process to come into compliance by March 2019. Multiple public meetings have been held on the transition plan over the last two years.

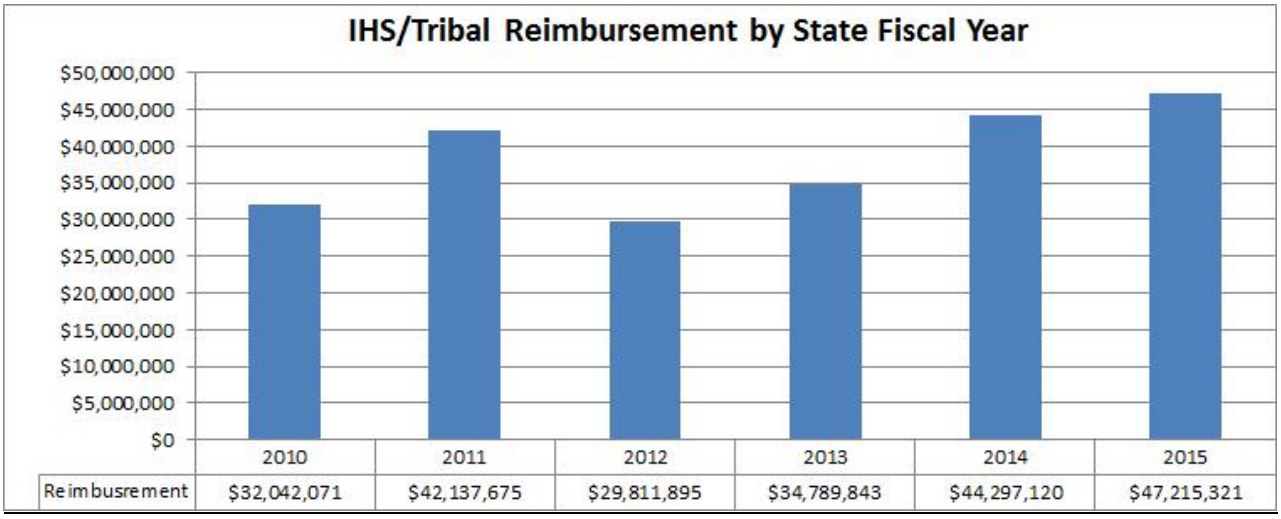
Indian Health Service (IHS) and Tribal Activities

A unique relationship exists between the federal government and Indian Tribes based on treaties and promises of health care to Native Americans. To fulfill this commitment, the federal government covers health care through grant based funds that go to IHS. IHS, in turn, contracts with Tribal Health Departments and Urban Indian Centers. This IHS funding is not an entitlement or insurance, it is a grant that has historically been underfunded to meet the health care needs of Indian people. IHS also does not cover all Indians. Only tribal members and their descendants are eligible.

In Montana, many tribal members primarily access health care through a delivery system that includes the IHS, Tribal Health Departments and Urban Indian Health Centers. The type and amount of services available vary in each location. While core funding primarily comes from the federal government, all of these entities seek reimbursement from Montana Medicaid and other third party coverage to meet their patients' needs.

IHS and Medicaid work together to provide medical care to an underserved population. While some Native Americans are eligible only for Medicaid, others may be eligible for both IHS and Medicaid services. In either of these circumstances, Medicaid reimburses IHS units for care provided. The Blackfeet, Crow/Northern Cheyenne and Fort Belknap hospitals provide both inpatient and outpatient services. Outpatient-only services are available in Hays, Heart Butte, Lame Deer, Lodge Grass, Poplar, Pryor and Wolf Point.

Two Tribal Health Departments - Rocky Boy Health Board and the Confederated Salish and Kootenai Tribal Health - have agreements in place with the federal government that offer them the opportunity to operate their own unique health care delivery system. These outpatient-only services are available in Arlee, Elmo, Pablo, Polson, St. Ignatius, Ronan, and Rocky Boy Agency.



	2010	2011	2012	2013	2014	2015
Reimbusrement	$32,042,071	$42,137,675	$29,811,895	$34,789,843	$44,297,120	$47,215,321

Five major urban Indian health centers provide care to Indians who reside off a respective Indian reservation. The Indian Health Board of Billings, the Helena Indian Alliance, the Indian Family Health Clinic of Great Falls, the Missoula Indian Center and the North American Indian Alliance of Butte operate and are paid as FQHCs and are not eligible under federal law to receive 100% federal reimbursement.

The Montana Medicaid Program passes through 100% federal reimbursement for covered medical services for Medicaid-eligible Native Americans who receive services through an IHS unit or Tribal Health Department. Medicaid reimburses outpatient IHS services on an encounter basis and pays for inpatient services using a per diem payment.

Indian Reservation Visits

DPHHS holds in high regard the government-to-government relationships that have been built with the tribal governing bodies and their respective Tribal Health Departments.

With assistance from the agency's Tribal Relations Manager, for the last four years an annual tour has been conducted in the fall across Montana. The DPHHS Director, State Medicaid Director and Tribal Relations Manager have travelled to each reservation to make personal visits to every tribal governing body (tribal council). These meetings provide an opportunity to discuss the Medicaid program and allow DPHHS to continue to learn more about how health care is delivered in each tribal community. Similar visits have been made to the IHS Units and Area Office.

The goal of these visits is to increase Medicaid reimbursement. Increased reimbursement will benefit both Tribes and the State. Tribes and the IHS units will benefit because Medicaid is an important revenue source for medical services they provide. Additional revenue allows more services to be delivered closer to home, thus increasing access to care. The State benefits because services provided by the Tribes (and IHS) are financed 100% by the federal government. As an example, if an eligible Indian person is served at a tribal health clinic rather than the private clinic in the next town, Montana saves $.34 on every Medicaid dollar spent.

Medicaid Payments				
Organization	Location	Eligible Client	Services Provided	Federal Match
Indian Health Service	Reservation	Tribal Member Or Descendent	In-patient – Blackfeet, Crow/Northern Cheyenne, Fort Belknap Outpatient – All Reservations – Services Offered vary	100% Federal Funds
Tribal Health (operating under a 638 agreement or compact)	Reservation	Tribal Member Or Descendent	Outpatient – Services Offered vary Nursing Facility Blackfeet, Crow	100% Federal Fund
Urban Indian Centers	Billings Butte Great Falls Helena Missoula	Tribal Member Or Descendent Plus Non-Indian People	Outpatient – Services Offered vary	65% Federal Funds/ 35% State Funds

Medicaid Revenue Reports
For the past several years, DPHHS has prepared Medicaid Revenue Reports and hand delivered these reports directly to the Tribal Governing bodies (Tribal Council), the Indian Health Service Units and the Area Office. Information is reported separately and includes Medicaid revenue received, types of services billed for and where payment is sent to. It is offered as a tool for Tribes and IHS as they compare information and identify opportunities for future billing. These reports have been well received and have become useful to the Tribes and the IHS.

Medicaid Tribal Consultations
DPHHS continues to have formal consultation with Tribal Governments, IHS and the Urban programs. These consultations are conducted through consultation letters and also formal consultation meetings. With the passage of Senate Bill 405 (Medicaid Expansion) in the 2015 Legislature, DPHHS held a formal Medicaid Tribal Consultation on August 19, 2015 in Helena to discuss the impacts of Medicaid expansion on Native Americans and tribal communities. The consultation was well attended.

Medicaid Administrative Match
Medicaid Administrative Match, commonly referred to as MAM, is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, Tribes who have entered into contracts with the state of Montana are reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal Cost Allocation Plan gives Tribes a mechanism to seek reimbursement for Medicaid administrative activities that Tribes perform. The program, the first of its kind in the country, began July 1, 2008. The Chippewa Cree and the Northern Cheyenne Tribe are currently under contract.

Medicaid Eligibility Determination Agreements
The partnerships that exist between DPHHS and the Tribes in Montana are important to delivering quality services in a cost efficient manner. In 2016, DPHHS entered into a new agreement with the Confederated Salish and Kootenai Tribes that allows the Tribe to determine Medicaid eligibility on the Flathead Indian Reservation. The Chippewa Cree Tribe has had a similar agreement in place for several years. Tribal members can now apply for services locally and barriers and delays are often reduced that may impede tribal members from obtaining Medicaid benefits and proper medical care. DPHHS is pursuing similar opportunities with the two other tribes eligible to enter into such agreements.

Nursing Facility Reimbursement
DPHHS and the Crow and Blackfeet Tribes negotiated a new payment rate that substantially increased reimbursement for tribally owned nursing facilities. This re-financing initiative made the nursing homes eligible for 100% federal match for the majority of their patients. With CMS approval of this state plan, starting in SFY 2015, revenue to each tribe is increased by approximately $1 million/year and savings to the state general fund are in excess of $600,000/year.

Medicaid Enrollment Charts

Most of the $1 billion in Medicaid expenditures supported private providers in the Montana economy in SFY 2015.

Enrollment and Expenditures by County SFY 2015

County	County Population 7/1/2015	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Total County Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
BEAVERHEAD	9,300	760	8%	33	$10,466,489	$13,770	9
BIG HORN	13,242	3,220	24%	2	$24,929,652	$7,742	56
BLAINE	6,577	1,196	18%	5	$13,181,911	$11,022	29
BROADWATER	5,689	414	7%	35	$3,351,357	$8,097	55
CARBON	10,408	660	6%	40	$7,090,787	$10,746	31
CARTER	1,180	54	5%	52	$706,826	$13,150	12
CASCADE	82,278	8,344	10%	21	$96,071,463	$11,514	24
CHOUTEAU	5,767	340	6%	42	$3,203,412	$9,417	46
CUSTER	12,135	1,148	9%	25	$15,224,961	$13,266	11
DANIELS	1,760	107	6%	41	$1,193,046	$11,159	26
DAWSON	9,625	552	6%	44	$8,402,401	$15,233	6
DEER LODGE	9,139	1,089	12%	17	$16,459,987	$15,115	7
FALLON	3,190	138	4%	53	$2,150,772	$15,557	5
FERGUS	11,427	954	8%	30	$15,019,763	$15,747	4
FLATHEAD	96,165	10,426	11%	19	$89,096,650	$8,545	50
GALLATIN	100,739	4,945	5%	49	$40,810,109	$8,253	53
GARFIELD	1,314	74	6%	45	$977,924	$13,305	10
GLACIER	13,647	3,404	25%	1	$32,751,242	$9,621	43
GOLDEN VALLEY	827	88	11%	20	$866,353	$9,817	40
GRANITE	3,240	175	5%	46	$2,177,410	$12,436	14
HILL	16,572	2,878	17%	7	$27,944,966	$9,710	42
JEFFERSON	11,645	906	8%	34	$24,128,689	$26,642	1
JUDITH BASIN	1,926	123	6%	39	$1,044,126	$8,477	51
LAKE	29,457	4,883	17%	8	$46,398,058	$9,501	44
LEWIS AND CLARK	66,418	5,953	9%	28	$60,249,112	$10,121	36
LIBERTY	2,408	117	5%	50	$1,392,088	$11,873	19
LINCOLN	19,052	2,558	13%	12	$25,808,205	$10,089	37
MADISON	1,683	374	22%	4	$4,399,135	$11,778	22
MCCONE	7,915	58	1%	56	$714,727	$12,430	15
MEAGHER	1,830	252	14%	11	$2,653,047	$10,538	32
MINERAL	4,251	619	15%	9	$5,828,801	$9,422	45
MISSOULA	114,181	10,959	10%	24	$121,084,448	$11,049	28
MUSSELSHELL	4,582	574	13%	15	$6,674,384	$11,633	23
PARK	15,972	1,161	7%	36	$14,259,161	$12,285	17

Enrollment and Expenditures by County SFY 2015 Continued

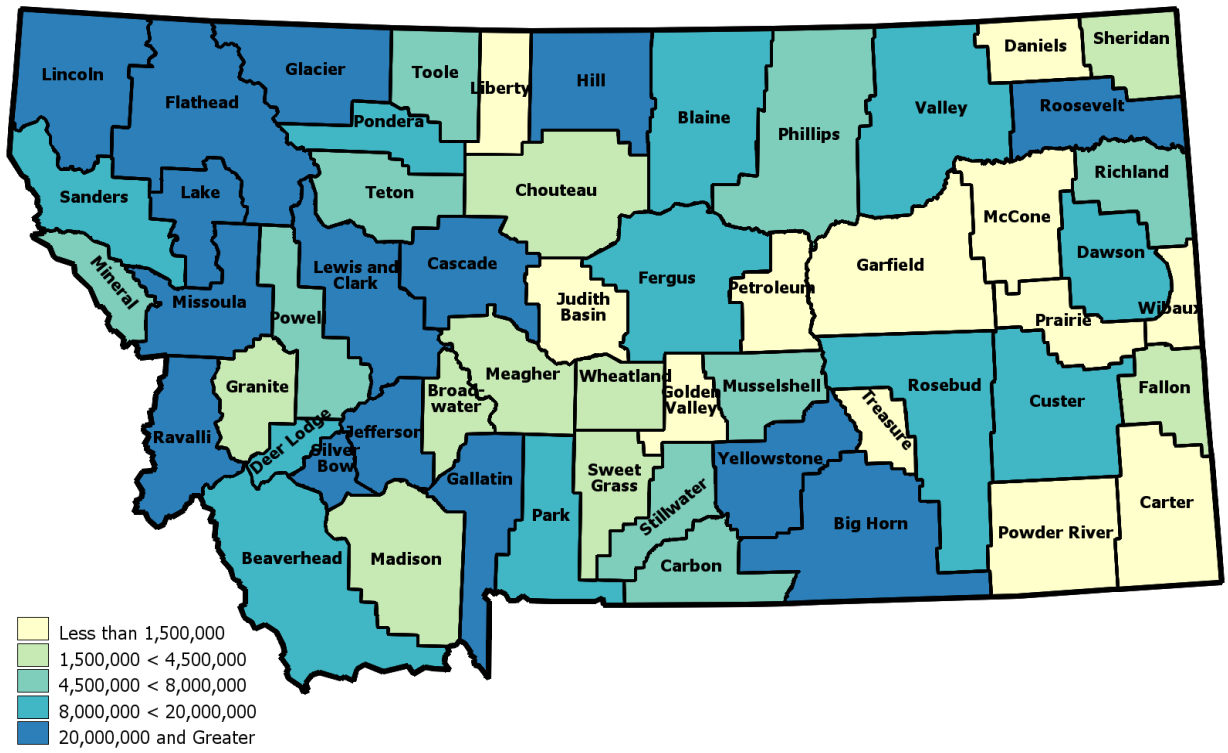
County	County Population 7/1/2015	Average Monthly Medicaid Enrollment	Percent on Medicaid	Rank by Percent on Medicaid	Total County Expenditures	Average Expenditure per Enrollee	Rank by Average Expenditure per Enrollee
PETROLEUM	475	23	5%	51	$190,138	$8,267	52
PHILLIPS	4,169	524	13%	14	$6,257,827	$11,942	18
PONDERA	6,184	874	14%	10	$9,060,251	$10,366	34
POWDER RIVER	1,773	59	3%	55	$1,336,510	$22,781	2
POWELL	6,840	623	9%	27	$7,984,703	$12,810	13
PRAIRIE	1,160	82	7%	37	$1,133,116	$13,776	8
RAVALLI	41,373	4,191	10%	22	$42,984,740	$10,257	35
RICHLAND	11,960	600	5%	48	$5,839,815	$9,736	41
ROOSEVELT	11,476	2,743	24%	3	$34,075,540	$12,424	16
ROSEBUD	9,398	1,669	18%	6	$14,979,048	$8,973	49
SANDERS	11,336	1,379	12%	16	$16,319,034	$11,838	21
SHERIDAN	3,687	216	6%	43	$2,267,931	$10,516	33
SILVER BOW	34,622	4,421	13%	13	$52,408,128	$11,854	20
STILLWATER	9,486	645	7%	38	$5,235,005	$8,123	54
SWEET GRASS	3,634	156	4%	54	$1,722,981	$11,068	27
TETON	6,104	504	8%	31	$5,083,379	$10,079	38
TOOLE	5,087	426	8%	29	$4,664,870	$10,940	30
TREASURE	697	57	8%	32	$526,082	$9,163	48
VALLEY	7,659	862	11%	18	$9,762,643	$11,329	25
WHEATLAND	2,110	198	9%	26	$1,835,762	$9,252	47
WIBAUX	1,130	58	5%	47	$1,045,372	$17,895	3
YELLOWSTONE	157,048	15,574	10%	23	$155,910,246	$10,011	39
Other / Institution		435			$0	$0	
Sub Total	**1,032,949**	**105,820**	**10%**		**$1,108,703,009**	**$10,477**	
Plan First		2,260			$1,342,442	$594	
QMB Only		4,200			$12,916,352	$3,075	
SLMB - QI Only		3,970			$5,377,417	$1,354	
HK (CHIP Funded)		8,314			$23,447,947	$2,820	
Grand Total	**1,032,949**	**147,849**	**14%**		**1,151,787,167**	**$7,790**	

Population estimates as of July 1, 2015. Columns may not sum to total due to rounding.

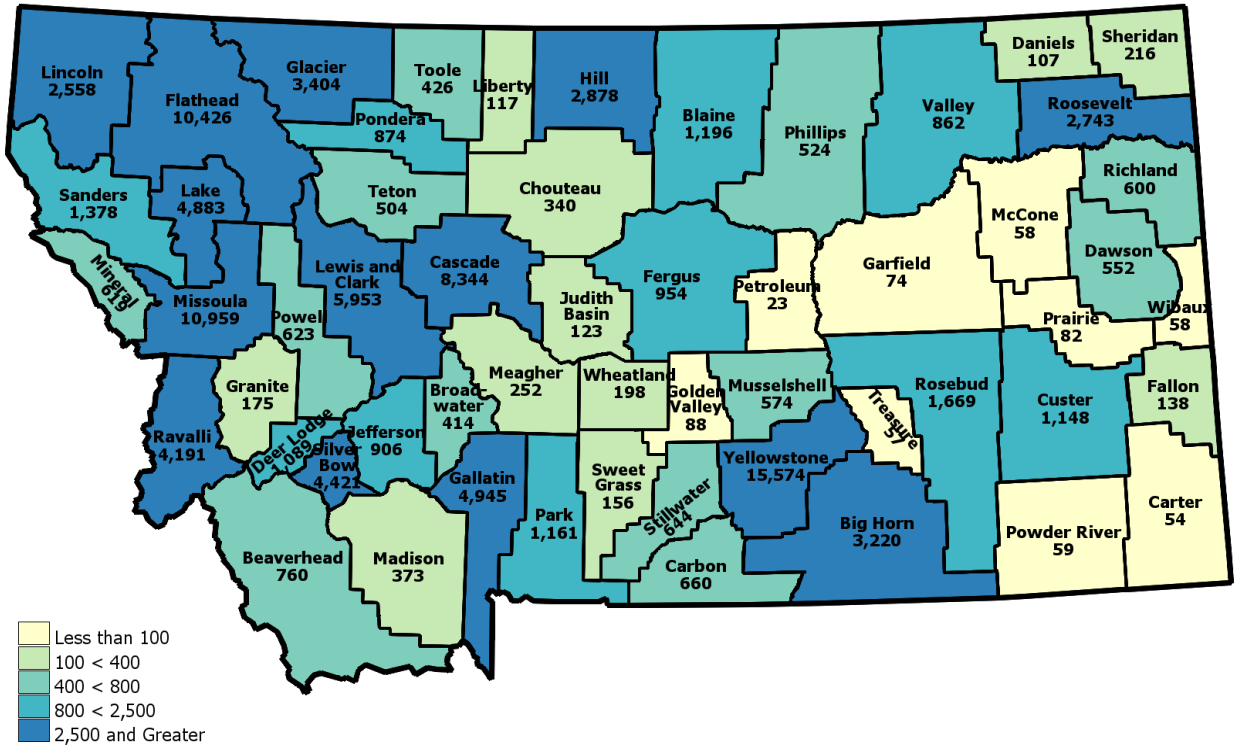
Excludes HMK (CHIP) and State Fund Mental Health. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums.

The charts on the following pages graphically represent the data presented in the above table.

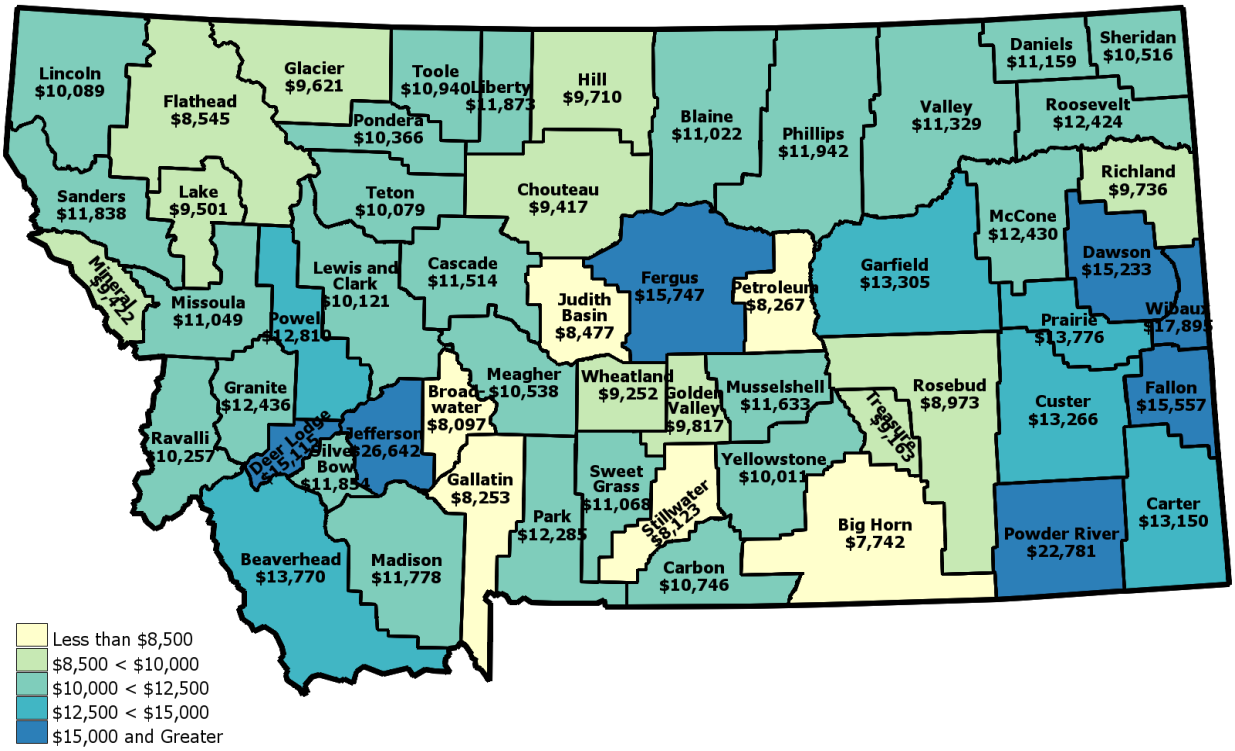
Total Medicaid Expenses
State Fiscal Year 2015



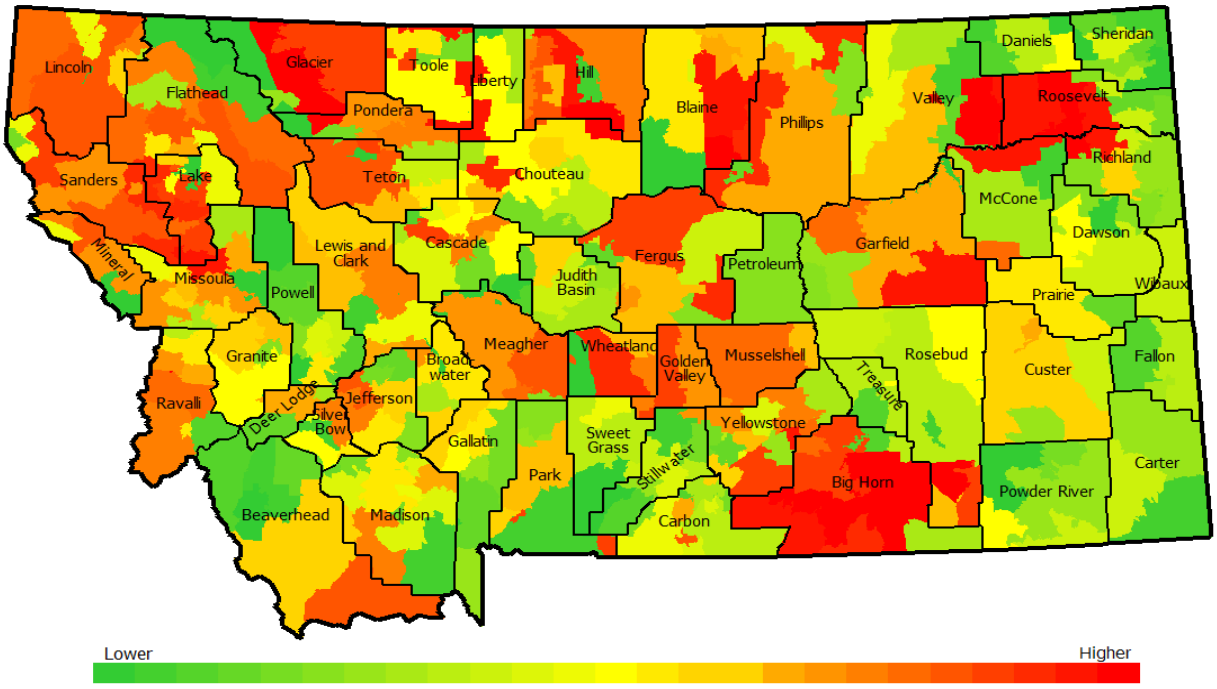
Medicaid Average Monthly Enrollment
State Fiscal Year 2015



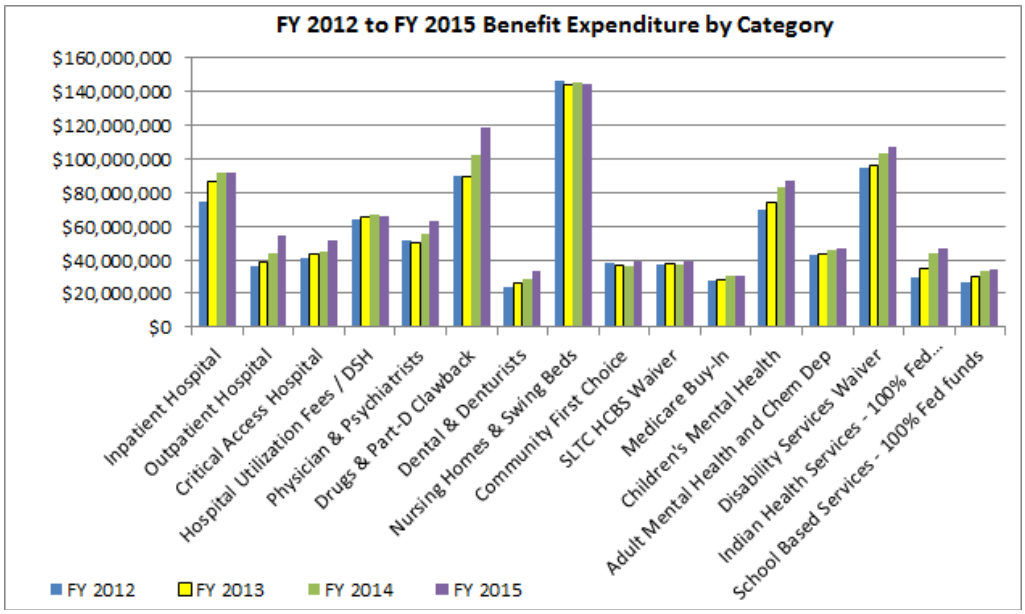
Average Expenditure per Enrollee
State Fiscal Year 2015



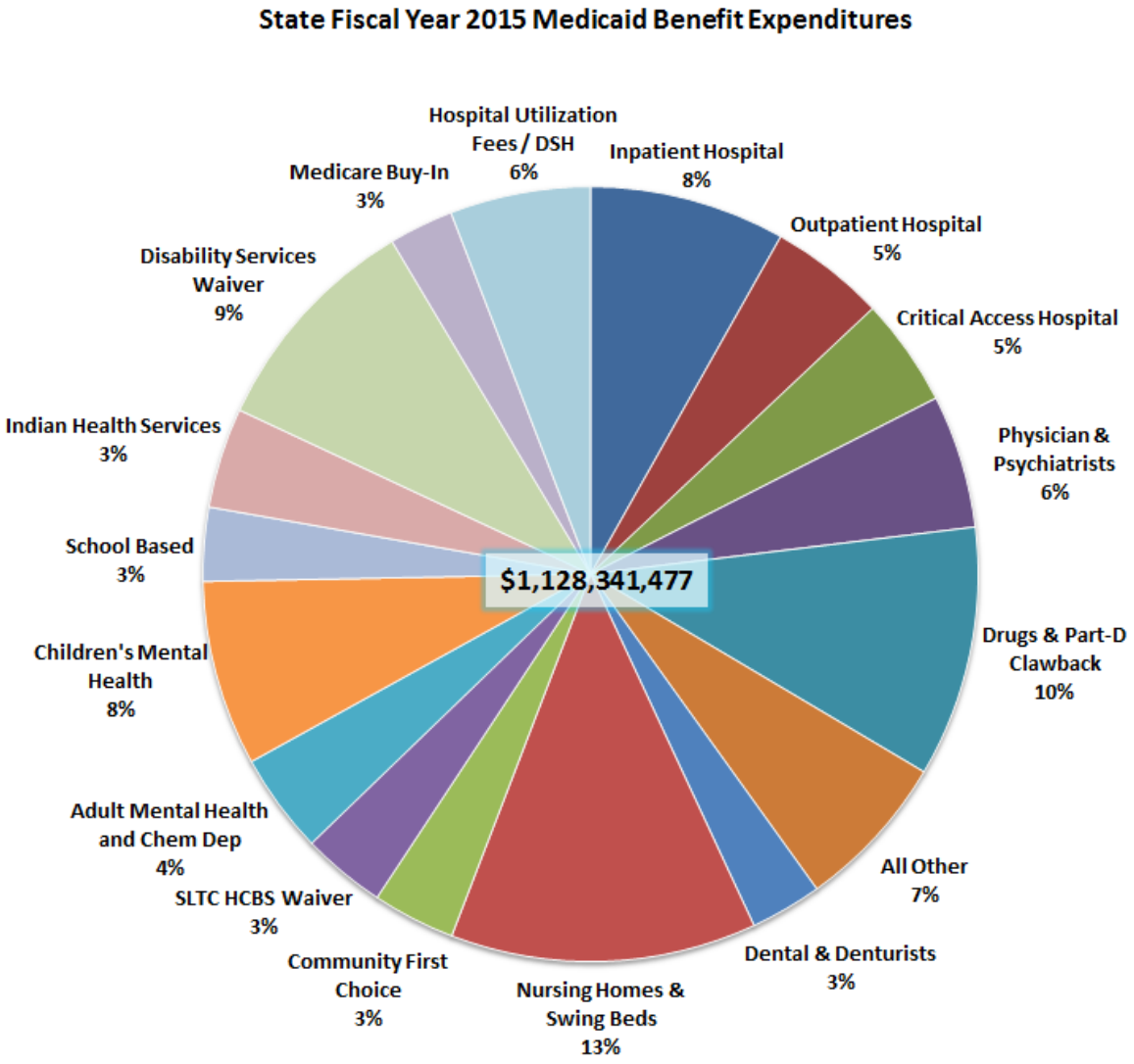
Medicaid Enrollment as Percent of County Population
State Fiscal year 2015



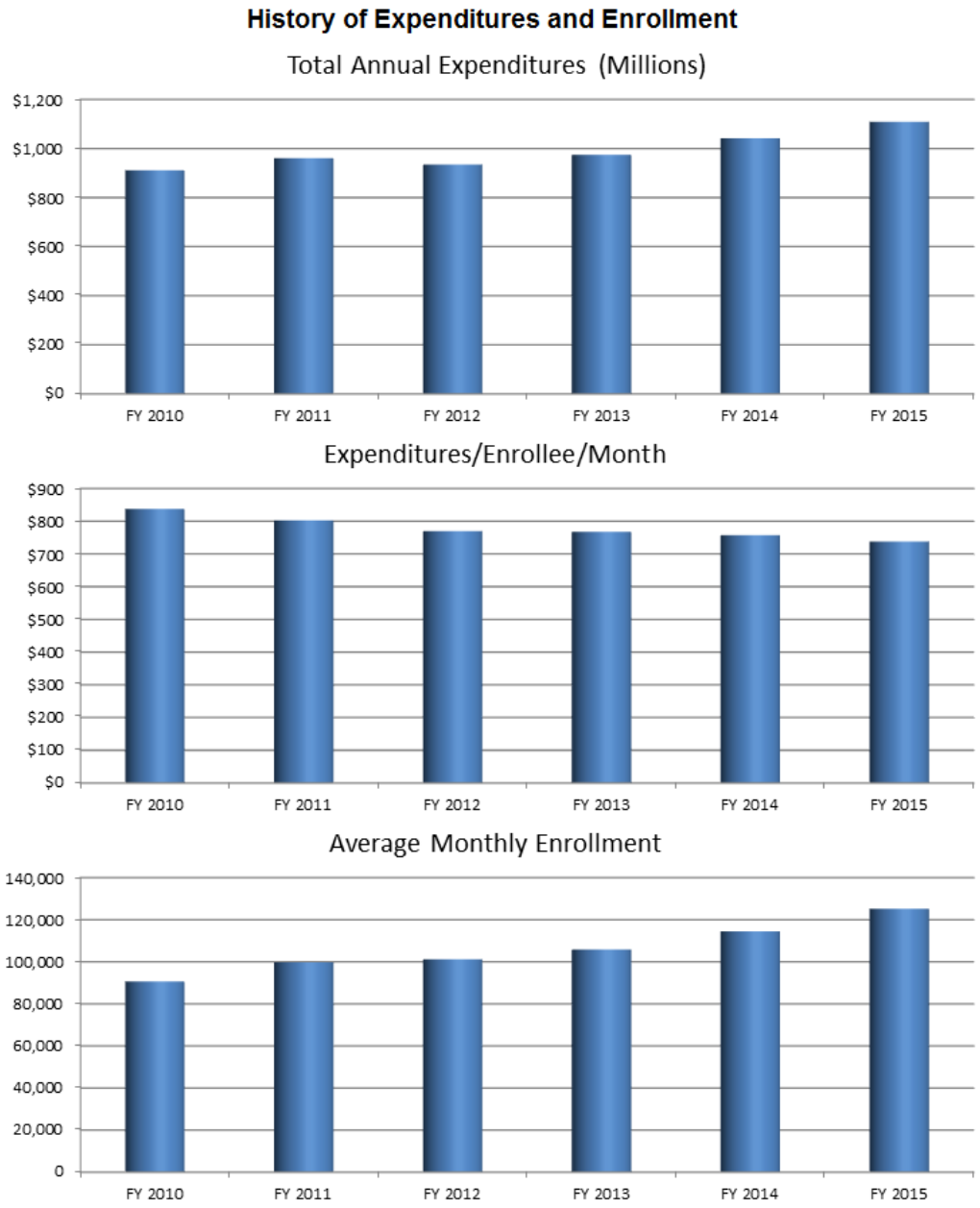
Source: QPath Eligibility



	Medicaid Expenditures			
Categories	FY 2012	FY 2013	FY 2014	FY 2015
Inpatient Hospital	$ 74,489,667	$ 86,086,299	$ 92,062,103	$ 92,088,032
Outpatient Hospital	36,466,846	38,496,962	44,150,457	54,285,285
Critical Access Hospital	40,941,235	43,042,900	44,833,368	51,083,866
Hospital Utilization Fees / DSH	63,996,224	65,313,864	67,251,332	66,179,993
Other Hospital and Clinical Services	20,345,818	21,332,893	23,746,552	27,084,467
Physician & Psychiatrists	51,425,986	50,330,118	55,654,507	62,702,635
Other Practitioners	16,925,264	17,253,488	19,179,326	21,383,021
Other Managed Care Services	8,600,743	10,016,120	11,020,874	11,465,128
Drugs & Part-D Clawback	89,391,673	89,567,591	102,554,496	118,136,470
Drug Rebates	(48,090,298)	(42,546,104)	(50,938,420)	(59,638,452)
Dental & Denturists	23,358,568	25,758,710	29,054,247	33,700,433
Durable Medical Equipment	14,207,693	14,953,087	14,785,273	14,629,634
Other Acute Services	2,557,646	2,821,029	3,158,315	3,814,555
Nursing Homes & Swing Beds	146,107,349	143,572,163	145,667,404	144,045,540
Nursing Home IGT	16,100,124	15,745,215	14,247,724	15,833,725
Community First Choice	38,022,265	37,126,380	36,595,480	38,914,140
Other SLTC Home Based Services	10,228,721	9,850,218	9,597,489	9,349,872
SLTC HCBS Waiver	37,640,206	37,746,857	36,786,236	39,462,431
Medicare Buy-In	27,934,865	28,153,453	30,266,987	30,444,789
Children's Mental Health	69,620,972	74,463,916	82,692,760	87,290,726
Adult Mental Health and Chem Dep	42,739,847	43,670,875	46,095,022	47,173,014
HIFA Waiver	5,660,297	7,450,312	9,755,145	18,325,244
Disability Services Waiver	94,295,143	95,600,410	103,305,690	106,923,045
Indian Health Services - 100% Fed funds	29,811,895	34,789,843	44,297,120	47,215,321
School Based Services - 100% Fed funds	26,978,363	29,606,656	33,047,616	34,702,382
MDC & ICF Facilities - 100% Fed funds	9,896,811	11,523,954	11,930,684	11,746,182
Total	$ 949,653,923	$ 991,727,209	$ 1,060,797,787	$ 1,128,339,220


State Fiscal Year 2015 Medicaid Benefit Expenditures
Hospital Utilization Fees / DSH 6%
Inpatient Hospital 8%
Medicare Buy-In 3%
Outpatient Hospital 5%
Disability Services Waiver 9%
Critical Access Hospital 5%
Indian Health Services 3%
Physician & Psychiatrists 6%
School Based 3%
$1,128,341,477
Drugs & Part-D Clawback 10%
Children's Mental Health 8%
All Other 7%
Adult Mental Health and Chem Dep 4%
SLTC HCBS Waiver 3%
Dental & Denturists 3%
Community First Choice 3%
Nursing Homes & Swing Beds 13%

The charts and tables below show the average per-member per-month reimbursement for various age groups and Medicaid eligibility categories. This calculation merges claims and eligibility data. While eligibility is updated over time, once a claim is processed, the information on the claim is static. The new methodology ensures a client's enrollment and reimbursement are counted in the same category and the updated enrollment information takes precedence over the claim information.



Enrollment and expenditures exclude administrative costs, Medicare Savings Plan, HMK (CHIP) and State Funded Mental Health. Decline in per-member reimbursement is attributable to increased enrollment of low cost children.

Medicaid Average Enrollment per Month							
		State Fiscal Year					
Age	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
< 1	Blind/Disabled	75	70	64	51	32	33
< 1	Child	5,642	5,854	5,817	5,848	6,241	6,581
1 to 5	Blind/Disabled	655	629	601	573	552	494
1 to 5	Child	19,357	22,170	22,526	23,850	25,431	25,760
6 to 18	Blind/Disabled	2,328	2,401	2,442	2,472	2,464	2,496
6 to 18	Child	26,970	31,599	32,928	35,839	40,421	44,174
19 to 20	Blind/Disabled	531	527	518	509	499	477
19 to 20	Adult	1,288	1,226	1,034	970	980	1,308
21 to 64	Blind/Disabled	15,364	15,835	16,247	16,541	16,621	16,353
21 to 64	Adult	11,487	12,352	11,858	11,932	14,023	20,178
65 +	Aged	6,461	6,952	6,917	7,030	7,001	7,034
65 +	Blind/Disabled	526	156	170	204	229	289
Total		**90,683**	**99,772**	**101,122**	**105,820**	**114,495**	**125,177**
All	Plan First			15	1,317	2,838	**2,260**
All	QMB	3,352	3,638	3,802	4,200	4,767	4,912
All	SLMB - QI	3,122	3,468	3,640	3,970	4,220	4,422
Total	**All Medicaid**	**97,156**	**106,878**	**108,579**	**115,307**	**126,319**	**136,771**
6 to 18	HK Med Plus	2,071	5,553	6,305	7,343	8,601	8,314
Total	**All Categories**	**99,227**	**112,431**	**114,883**	**122,650**	**134,920**	**145,086**

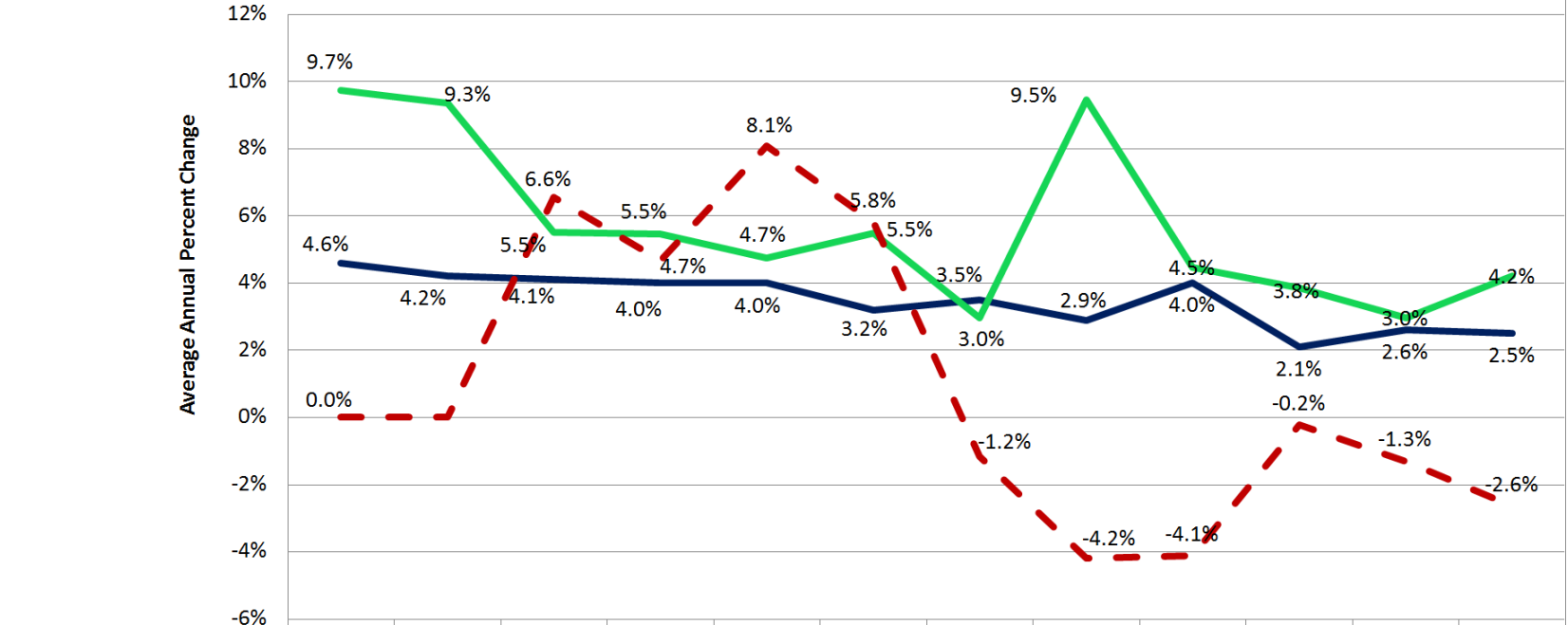
Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

Medicaid Per Member Per Month Reimbursement							
		State Fiscal Year					
Age	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
< 1	Blind/Disabled	$5,972	$3,976	$4,995	$4,436	$5,010	$5,729
< 1	Child	$661	$724	$648	$763	$777	$715
1 to 5	Blind/Disabled	$1,656	$1,748	$1,711	$1,638	$1,682	$1,758
1 to 5	Child	$168	$168	$156	$162	$168	$185
6 to 18	Blind/Disabled	$1,919	$1,899	$1,907	$2,012	$2,112	$2,123
6 to 18	Child	$353	$336	$326	$329	$340	$350
19 to 20	Blind/Disabled	$1,284	$1,545	$1,446	$1,277	$1,544	$1,364
19 to 20	Adult	$713	$758	$702	$750	$709	$628
21 to 64	Blind/Disabled	$1,811	$1,797	$1,719	$1,753	$1,803	$1,862
21 to 64	Adult	$630	$648	$624	$641	$657	$591
65 +	Aged	$2,499	$2,467	$2,440	$2,377	$2,381	$2,407
65 +	Blind/Disabled	$1,244	$1,220	$1,133	$1,113	$1,163	$1,148
Total		**$838**	**$802**	**$770**	**$768**	**$758**	**$738**
All	Plan First			$84	$63	$48	**$50**
All	QMB	$217	$221	$221	$215	$222	$219
All	SLMB - QI	$108	$119	$114	$108	$105	$101
Total	**All Medicaid**	**$793**	**$760**	**$729**	**$717**	**$700**	**$687**
6 to 18	HK Med Plus	$183	$208	$215	$232	$241	$235
Total	**All Categories**	**$780**	**$733**	**$701**	**$688**	**$671**	**$662**

For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.

Medicaid Reimbursement							
		State Fiscal Year					
Age	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
< 1	Blind/Disabled	$5,362,670	$3,343,757	$3,825,905	$2,692,546	$1,923,808	$2,280,305
< 1	Child	$44,778,514	$50,860,136	$45,245,889	$53,559,143	$58,200,311	$56,454,831
1 to 5	Blind/Disabled	$13,007,916	$13,206,198	$12,346,720	$11,270,602	$11,135,687	$10,422,672
1 to 5	Child	$39,007,382	$44,647,795	$42,042,875	$46,479,358	$51,250,087	$57,173,767
6 to 18	Blind/Disabled	$53,596,199	$54,734,321	$55,901,358	$59,677,919	$62,452,057	$63,596,059
6 to 18	Child	$114,403,684	$127,349,418	$128,722,732	$141,486,990	$165,103,532	$185,490,929
19 to 20	Blind/Disabled	$8,182,623	$9,765,874	$8,985,431	$7,794,820	$9,252,773	$7,799,410
19 to 20	Adult	$11,021,687	$11,151,476	$8,705,975	$8,729,977	$8,343,002	$9,853,796
21 to 64	Blind/Disabled	$333,865,537	$341,502,996	$335,211,535	$347,971,294	$359,662,833	$365,445,639
21 to 64	Adult	$86,845,289	$96,114,881	$88,734,992	$91,843,988	$110,588,842	$143,029,831
65 +	Aged	$193,722,882	$205,831,614	$202,537,556	$200,499,434	$200,049,058	$203,172,599
65 +	Blind/Disabled	$7,842,873	$2,279,733	$2,310,475	$2,731,286	$3,192,874	$3,983,169
Total		**$911,637,256**	**$960,788,199**	**$934,571,442**	**$974,737,357**	**$1,041,154,862**	**$1,108,703,009**
All	Plan First			$15,294	$1,002,030	$1,641,318	**$1,342,442**
All	QMB	$8,711,806	$9,630,292	$10,079,707	$10,831,903	$12,679,171	$12,916,352
All	SLMB - QI	$4,028,815	$4,936,396	$4,987,479	$5,155,919	$5,322,436	$5,377,417
Total	**All Medicaid**	**$924,377,877**	**$975,354,887**	**$949,653,923**	**$991,727,209**	**$1,060,797,787**	**$1,128,339,220**
6 to 18	HK Med Plus	$4,539,034	$13,887,446	$16,263,467	$20,471,294	$24,837,340	$23,447,947
Total	**All Categories**	**$928,916,911**	**$989,242,333**	**$965,917,390**	**$1,012,198,503**	**$1,085,635,127**	**$1,151,787,167**

Categories may not sum to totals due to rounding. For QMB only enrollees, Medicaid pays for Medicare Premiums, co-insurance, and deductibles. For SLMB - QI only enrollees, Medicaid pays for Medicare Premiums. HK Med Plus are Medicaid clients age 6 to 18 that are funded through CHIP. Plan First clients receive a limited benefit for family planning services.



	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Health care CPI	4.6%	4.2%	4.1%	4.0%	4.0%	3.2%	3.5%	2.9%	4.0%	2.1%	2.6%	2.5%
Insurance Premiums	9.7%	9.3%	5.5%	5.5%	4.7%	5.5%	3.0%	9.5%	4.5%	3.8%	3.0%	4.2%
Medicaid Reimbursement	0.0%	0.0%	6.6%	4.7%	8.1%	5.8%	-1.2%	-4.2%	-4.1%	-0.2%	-1.3%	-2.6%

Source/Notes: Health Care CPI from BLS. Insurance Premiums from *Kaiser/HRET 2014 Annual Survey: Average Calendar Year Premiums*. Medicaid reimbursement is on per-member basis. The decline is attributabale to increased enrollment of low cost children.

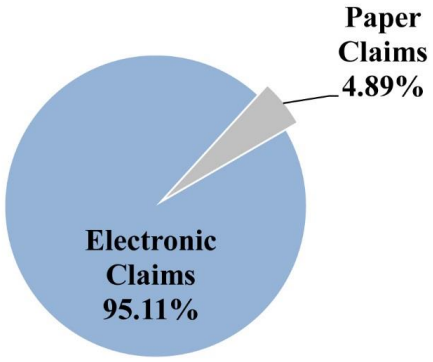
Providers

Medicaid provides services through a statewide network of private and public providers. In SFY 2016, payments were made to 14,526 providers who participated and offered services to Medicaid members. These providers predominately live and work in communities across the state. In many cases (nursing facilities, hospitals) they are a major employer. In SFY 2016, Medicaid reimbursement of over $1 billion was a vital part of the Montana economy.

Claims Processing

DPHHS contracts with Xerox to process claims for reimbursement. Xerox meets the rigorous requirements established by CMS to be a Medicaid fiscal agent. Xerox processed nearly 9.9 million Medicaid claims in SFY 2016.

Claim Type	*Number Processed*	*% of Total*
Paper Claims	487,507	4.89 %
Electronic Claims	9,475,735	95.11%
Total Claims	9,963,242	100%



Rate Setting Process

The Montana Medicaid Program uses several methods to establish payment rates for services. The methodology used for reimbursement varies from service to service.

Reimbursement Systems for Hospitals
Montana Medicaid's reimbursement systems include a Diagnosis Related Groups system for inpatient services for some hospitals, Ambulatory Payment Classification for these same hospitals for outpatient hospital services, cost based reimbursement for hospitals classified as Critical Access Hospitals (CAHs) and Resource Based Relative Value Scale (RBRVS) for physician/professional services. These reimbursement systems use cost, utilization, and other factors – such as measures of relative value or relative acuity – in determining provider payment rates.

Resource Based Relative Value System (RBRVS)
Montana Medicaid reimburses physicians and other providers who bill on CMS-1500 forms with an adaption of Medicare's RBRVS. Reimbursement is based on the value of a service relative to all other services. The calculations compare the resources needed for a specific service (office expenses, malpractice insurance, and provider work effort and complexity) to those needed for other services. Each service code is assigned one or more relative value units designating its position on the relative value scale. This system was developed nationally by CMS, the American Medical Association, and non-physician provider associations; it is adjusted annually. Montana receives the benefit of this large, ongoing investment in research and policy-making without yielding control of costs. The fee for each code is determined by multiplying the RVU by a conversion factor with a dollar value. The conversion factor is Montana-specific to insure the overall budget neutrality of the Medicaid appropriation. The conversion factor is adjusted annually based on the Montana Legislature's most recent biennial appropriation.

Price-Based Reimbursement System
Nursing facilities are reimbursed under a case mix, price-based system where rates are determined annually, effective July 1. Each nursing facility receives a facility specific rate. The statewide price for nursing facility services is established annually through a public process. Each nursing facility's payment is comprised of two components, the operating component including capital and the direct resident care component. Each nursing facility receives the same operating per diem rate, which is 80% of the statewide price. The remaining 20% of the statewide price represents the direct resident care component of the rate and is acuity adjusted using the minimum data set (MDS). Each facility's direct resident care component rate is specific to the facility based on the acuity of the Medicaid residents served in the facility.

Fee-for-Service
Fee-for-service simply means that a fee is established for a certain product or service. Pharmacy services are one of the major services reimbursed under the fee for service methodology. Pharmacies receive both a professional dispensing fee for each prescription plus the cost of the ingredient. Ingredient costs are reimbursed at the average acquisition cost for each product.

Medicaid uses the Medicare fee-for-service rates and per encounter payment systems for some programs. This allows efficient maintenance and the use of already established fee schedules for certain areas. Some examples of programs that use Medicare fee schedules include Durable Medical Equipment, Ambulatory Surgical Centers, and FQHCs.

Cost Containment Measures

The Medicaid program continues to develop cost containment measures that enhance the cost effectiveness and efficiency of the program. Some examples include:

Health Outcome Initiatives

- **Early/Elective Inductions and Cesarean Sections -** Elective inductions, cesarean sections, and early deliveries all increase the risk to both mother and infant, and there is no evidence that they confer any health benefits in the absence of medical indications. Reimbursement is reduced for non-medically necessary inductions prior to 39 weeks and 0/7 days or non-medically necessary cesarean deliveries at any gestation. This policy began October 1, 2015.

- **Long Acting Reversible Contraceptives (LARC) –** Effective January 1, 2015, hospitals can bill for the LARC, inserted at the time of delivery, separately to receive reimbursement and increase the use of LARC and reduce unplanned pregnancies.

- **Promising Pregnancy Care (PPC) –** Preterm birth is a serious public health issue that increases risks for both mother and baby. A 2007 study showed low risk women who participated in group care are 33% less likely to deliver a preterm infant. The women also reported improvements in pregnancy knowledge, readiness for labor, satisfaction with care, and breastfeeding initiation rates. PPC consists of 10 group-driven sessions conducted at the time of the prenatal visit. Classes last between 1.5-2 hours and each woman is provided with a book that includes educational materials and ways to keep track of their personal pregnancy information. Specific information is required to be presented during the classes, including healthy lifestyle choices, family planning, postpartum care, and ways to prevent sudden infant death syndrome and shaken baby syndrome. Medicaid began coverage in January 1, 2017.

- **Lactation Services-** In 2011, the Surgeon General released a report indicating a 32% higher risk of childhood obesity and 64% higher risk of type 2 diabetes for children who were not breastfed. It also reports a 56% higher risk of sudden infant death syndrome in children who were not breastfed. Mothers also benefit. The 2011 Surgeon General's Call to Action to Support Breastfeeding indicates a 4% higher risk of breast cancer and a 27% higher risk of ovarian cancer in women who have never breastfed. Effective January 1, 2016, lactation services in outpatient hospitals are now reimbursable under Montana Medicaid. Members have access to a prenatal lactation group class and postnatal one on one lactation consultations.

- **Educational/Group Services at set rate in FQHCs/RHCs and CAHs** - Effective October 1, 2016 specific group education services performed in FQHCs, RHCs, CAHs, IHS and Tribal Health Clinics will be reimbursed at a set fee outside of their all-inclusive rate or their cost to charge rate. These services currently include the Diabetes Prevention Program, Diabetes Self-Management Education, and Promising Pregnancy Care.

School Based Services

- Services previously provided by local school districts have been refinanced using federal Medicaid match. This allows children to receive additional needed services such as mental health care and speech therapy at no additional cost to the school district. The Office of Public Instruction certifies the match for the general fund portion for Medicaid reimbursed health-related services provided as part of the child's Individualized Education Plans.

Physician/Mid-Level Practitioner

- **Nurse Advice Line** - Toll free, confidential advice line available to all members with Medicaid and HMK *Plus*. Registered nurses triage caller's symptoms and guide callers to obtain care in appropriate settings (self-care, physician, or urgent or emergent care).

- **Team Care** - Medicaid members with a history of using Medicaid services at an amount or frequency that is not medically necessary are required to participate in order to control utilization. Team Care members are managed by a team consisting of a Passport to Health primary care provider, one pharmacy, the Nurse Advice Line, and DPHHS staff. Team Care currently has 650 members.

- **Passport to Health** - Primary Case Management Program was implemented in 1993 to reduce medical costs and improve quality of care. A member chooses one primary care provider who performs or provides referrals for the member's care.

Patient-Centered Medical Home

- The Patient-Centered Medical Home (PCMH) model of care, implemented in December 2014, is designed to provide Medicaid and HMK *Plus* members with a comprehensive, coordinated approach to primary care. Primary care providers (PCPs) receive additional reimbursement for each member enrolled for providing enhanced services, reporting quality measures, and supporting comprehensive infrastructure. DPHHS has contracts with five providers, across the state, to test the efficiency of the program. Over 9,000 members are being served in a PCMH.

Comprehensive Primary Care Plus (CPC+):

- Montana Medicaid (along with Blue Cross Blue Shield Montana and Pacific Source) was chosen as one of 14 regions to participate in the CPC+ Program in coordination with Medicare. CPC+ is a national, advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States. The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. Effective January 1, 2017, CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making.

Hospital

- **Out-of-State Inpatient and Outpatient Hospital** - Prior authorization requiring a mandatory approval for all inpatient hospital services out-of-state. Encourages the utilization of available health resources in-state.

- **All Patient Refined-Diagnosis Related Grouper (APR-DRG) Charge Cap** – This became effective on October 1, 2016. Hospitals in the APR-DRG system are reimbursed the lesser of billed charges or APR-DRG rate.

Transportation

- Prior authorization and assistance with obtaining medically necessary transportation services.

Eyeglasses

- Bulk purchase of eyeglasses through a contract with a significantly reduced price.

Pharmacy

- **Prior Authorization -** Mandatory advance approval of certain medication before they are dispensed for any medically accepted indication. This process is handled either at the Drug PA unit or through the pharmacy claims processing program.

- **Drug Utilization Review** - Prospective and retrospective review of drug use to ensure proper utilization.

- **Over-the-Counter Drug Coverage** - When prescribed by a physician a cost effective alternative to higher priced federal legend drugs.

- **Mandatory Generic Substitution** - Requires pharmacies to dispense the generic form of the drug which is less expensive than brand name drugs.

- **Dispensing Restrictions** - Minimum or maximum quantities per prescription or number of refills.

- **Preferred Drug List and Supplemental Rebates** - Medicaid's Drug Utilization Review Board/Formulary committee selects drugs in various classes of medications. Extensive review of the medications by the Board yields drugs that represent the best value to the Medicaid program. Many of the preferred drugs also provide supplemental rebates above what is currently offered through the federal Medicaid program.

- **Drug Rebate Collection** - The Department has four full-time staff dedicated to the rebate program and the use of the Drug Rebate Analysis and Management System. The staff conducts claims audits and invoice audits prior to invoicing pharmaceutical manufacturers. These staff procedures assure more accurate invoices being sent to the manufacturers and eliminate or reduce disputes with the manufacturers. This results in more timely payments being received from the manufacturers. Drug rebates average approximately 50% of the Medicaid pharmacy expenditures. In SFY 2015, drug rebates were approximately $46.2 million.

- **Average Acquisition Cost (AAC)–** Effective July 2016, Medicaid replaced the estimated acquisition cost reimbursement methodology previously used and now sets drug ingredient reimbursement as close to actual acquisition as possible. Acquisition cost is based on drug invoice data (often coming directly from the wholesaler) collected via acquisition cost surveys from Montana pharmacy providers. AAC pricing is part of the Department's lesser of drug pricing algorithm and results in several million dollars in savings to the state.

- **Consistent formulary** – Children that change eligibility between HMK Plus and HMK are now on the same prescription drug formulary. This provides continuity of care and decreases drug changes.

Long Term Care

- **Tribal Nursing Facility Rates** - DPHHS and the Crow and Blackfeet Tribes negotiated a new payment rate that substantially increased reimbursement for tribally owned nursing facilities. This re-financing initiative made the nursing homes eligible for 100% federal match for the majority of their patients. With CMS approval of this state plan, starting in SFY 2015, revenue to each Tribe is increased by approximately $1 million/year and savings to the state general fund are in excess of $600,000/year.

- **Money Follows the Person (MFP)** - Montana was awarded a MFP demonstration grant from CMS to augment existing Montana's community-based long term services and supports and to increase HCBS. The grant provides a temporary increase in the federal share of the Medicaid matching rate to pay for services to people who are already receiving Medicaid funded care in an institutional setting and choose to move into certain types of community settings.

  Montana's MFP demonstration project targets persons in the Montana Developmental Center transitioning to the community; persons with complex needs (including traumatic brain injury), Severe Disabling Mental Illness, physical disabilities, and/or elders in nursing homes; and individuals aged 18-21 in the Montana State Hospital.

  All waiver and demonstration services receive an enhanced FMAP rate for Medicaid benefits for a period of 365 days of service. At day 366, a participant is served under a HCBS waiver at regular FMAP. This grant was extended in the amount of $9,306,595. Montana will transition individuals to HCBS waiver programs with MFP funds through December 31, 2017. MFP funding will continue through the first quarter of calendar year 2019.

- **Community First Choice** (CFC) **-** Montana is the fourth state to have a CFC state plan approved by the CMS to implement the CFC option of Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Montana's Medicaid SPA adding CFC services was approved on July 8, 2014, with a retroactive effective date of October 1, 2013. Montana's program covers home and community-based attendant services and supports to assist members with activities of daily living, instrumental activities of daily living, health-related related tasks, and related support services, as specified in the ACA regulations. The incentive to adopt this option is a permanent 6% increase in the federal share of Medicaid's cost (the FMAP rate) for CFC services.

- **Long Term Care Insurance** - Long term care insurance partnerships were added to the insurance options that are available in Montana for consumers. Purchase of insurance will help defray Medicaid costs in the future once partnership policies are utilized. An institutionalized/waiver individual or spouse who purchased a Qualified Long Term Care Partnership (LTC) policy or converted a previously-existing LTC policy to a Qualified LTC Partnership policy on or after July 1, 2009 may protect resources equal to the insurance benefits received from the policy.

  Asset protection through LTC Partnership is available only after Qualified LTC Partnership policy lifetime limits have been fully exhausted on LTC services for the Medicaid applicant or spouse. The amount of assets protected will be equal to the insurance benefits paid.

- **Prior authorization** - Prior authorization for most community based services.

- **Intergovernmental fund transfer** - Intergovernmental fund transfer for counties to provide additional payments to at-risk nursing facilities. Participating counties pay a fee that is matched with federal funds. These funds are then re-distributed to facilities.This is an important component of nursing home reimbursement.

- **Nursing Facility Transitions** - Nursing facility transitions have been used as a vehicle to provide services in the least restrictive setting to consumers who move from the nursing facility into community services; with dollars for services following them from the nursing facility budget in a money follows the person approach to rebalancing the long term care system. Typically individuals can be served in the community at a lower cost than in the institution. Since SFY2004, over 300 people have transitioned from nursing facilities into community services; with dollars for services following them from the nursing facility into the community. During SFY 2014, 72 members were transitioned from nursing facilities into community service placements. Another nursing facility transition occurred in SFY 2017 targeting members residing in nursing facilities who were also on the HCBS Big Sky Waiver wait list as of June 30, 2016. During this time, a total of 37 individuals were transitioned into the community.

Third Party Liability (TPL)

- The Human and Community Services and Quality Assurance Divisions lead the Department's efforts to identify third parties liable for payment of a Medicaid member's medical costs. Third parties include Medicare, private health insurance, auto accident policies and workers' compensation. Medicaid also recovers payments made for certain long term services from the estates of members who have passed away. This identification of third party liability resulted in avoidance of over $179 million in SFY 2015 and $165.4 million in SFY 2016.

Medicaid Buy-In and Medicare Savings Program

- Medicare Buy-in results in major cost avoidance for Montana Medicaid by making Medicare the primary payer for people who have both Medicare and Medicaid ("full" dual eligible). Medicare Part-B premiums are paid directly to CMS for certain low income "full" dual eligible. Medicare Part-A premiums are also paid for those Medicaid enrollees receiving Supplemental Security Income SSI payments who become entitled to Medicare at age 65.

The Medicare Savings Program also provides Medicare Buy-in benefits to people with Medicare who are not eligible for full Medicaid services but have limited income and assets. Depending on income, an individual may be classified as a qualified Medicare Beneficiary (QMB), which covers both the Medicare Part A and B premiums and some co-payments and deductibles; Specified Low Medicare Beneficiary (SLMB), which covers the Medicare Part-B premium only; or Qualified Individual (QI-1), which covers the Medicare Part-B premium through 100% federal dollars. All three programs automatically entitle the enrollee to Low Income Subsidy (LIS) or "Extra Help" status for the Medicare Prescription Drug Plan (Part-D).

Due to the cost efficiency of having Medicare as the first payer, a concerted effort is ongoing to ensure that anyone meeting the eligibility criteria is enrolled.

Program and Payment Integrity Activities

- Improper payments in Medicaid drain vital program dollars, impacting members and taxpayers. Such payments include those made for treatments or services not covered by program rules; that were not medically necessary; that were billed but never actually provided; or that have missing or insufficient documentation to show the claim was appropriate. Improper payments are most often the result of inadvertent errors due to clerical errors or a misunderstanding of program rules. Medicaid also has programs to detect fraud and abuse. Fraud involves an intentional act to deceive for gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices. Medicaid's claim processing system, known as the Medicaid Management Information System (MMIS), has hundreds of edits that stop payment on many billing errors. However, no computer system can be programmed to prevent all potential Medicaid billing errors.

  Medicaid protects taxpayer dollars and the availability of Medicaid services to individuals and families in need by coordinating or cooperating with efforts to identify, recover and prevent inappropriate provider billings and payments.

  Two state agencies share responsibility for protecting the integrity of the state Medicaid program. The Quality Assurance Division is responsible for insuring proper payment and recovering misspent funds and the Attorney General's Medicaid Fraud Control Unit (MFCU) is responsible for investigating and ensuring prosecution of Medicaid fraud. At the federal level, both the CMS and the Office of Inspector General (OIG) of the Department of Health and Human Services oversee state program and payment integrity activities. Both CMS and OIG audit the state's Medicaid program on a regular basis.

  The Medicaid program is also audited by two federal audit contractors. The Payment Error Rate Measurement (PERM) audit is conducted every three years. This is a comprehensive audit of claims payment and eligibility determination. The total overpayment identified for Montana in 2014 was $75,044. Montana's eligibility audit error rate was 0.4% compared to a national error rate of 3.3%. The fee-for-service payment error rate was 5.8%. This compares to a 10.6% error rate nationally. The second federal audit is the Recovery Audit Contractors (RAC), which is targeted to look at high risk and/or high cost services. In SFY 15, RAC recoveries totaled $485,113 and in SFY 16 the total was $871,480. The contractor receives 10% of recovered funds.

Actions resulting from the program and payment integrity efforts may include:

- Clarification and streamlining of Medicaid policies, rules and billing procedures
- Increased payment integrity, recovery of inappropriately billed payments and avoidance of future losses
- Education of providers regarding proper billing practices
- Termination of providers from participation in the Medicaid program
- Referrals to the Attorney General's Medicaid Fraud Control Unit (MFCU)

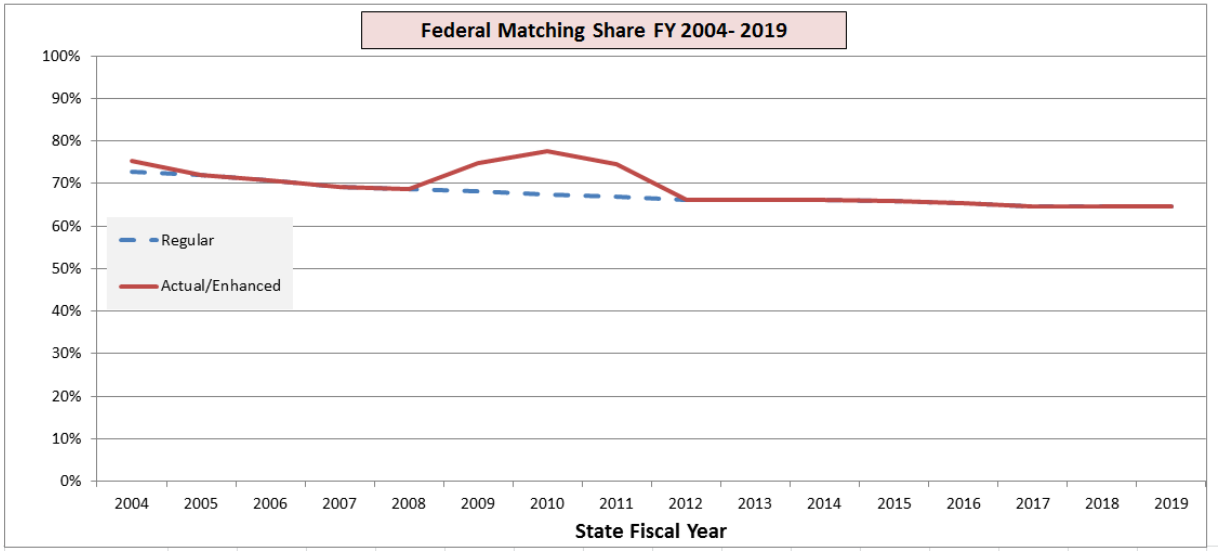
Expenditure Analysis

Medicaid services are funded by a combination of federal and state (and, in some situations, local) funds. The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita income compared to the national average. For example in State Fiscal Year 2016 for every Medicaid dollar, the federal share was 65.30 cents and the Montana state share was 34.70 cents.

Montana Medicaid Benefits Federal Matching

State Fiscal Year	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Federal Match Rate	68.59%	74.80%	77.65%	74.58%	66.21%	66.04%	66.25%	65.92%	65.30%	64.72%
State Match Rate	31.41%	25.20%	22.35%	25.42%	33.79%	33.96%	33.75%	34.08%	34.70%	35.28%

The following chart illustrates the increase in the federal share of Medicaid costs that were made available by the federal government during past economic downturns. The increase in federal match for FY2003-04 was implemented as a result of the Jobs and Growth Tax relief Reconciliation Act of 2003. Federal match was increased in FY2008-11 due to the enactment of the American Recovery and Reinvestment Act.

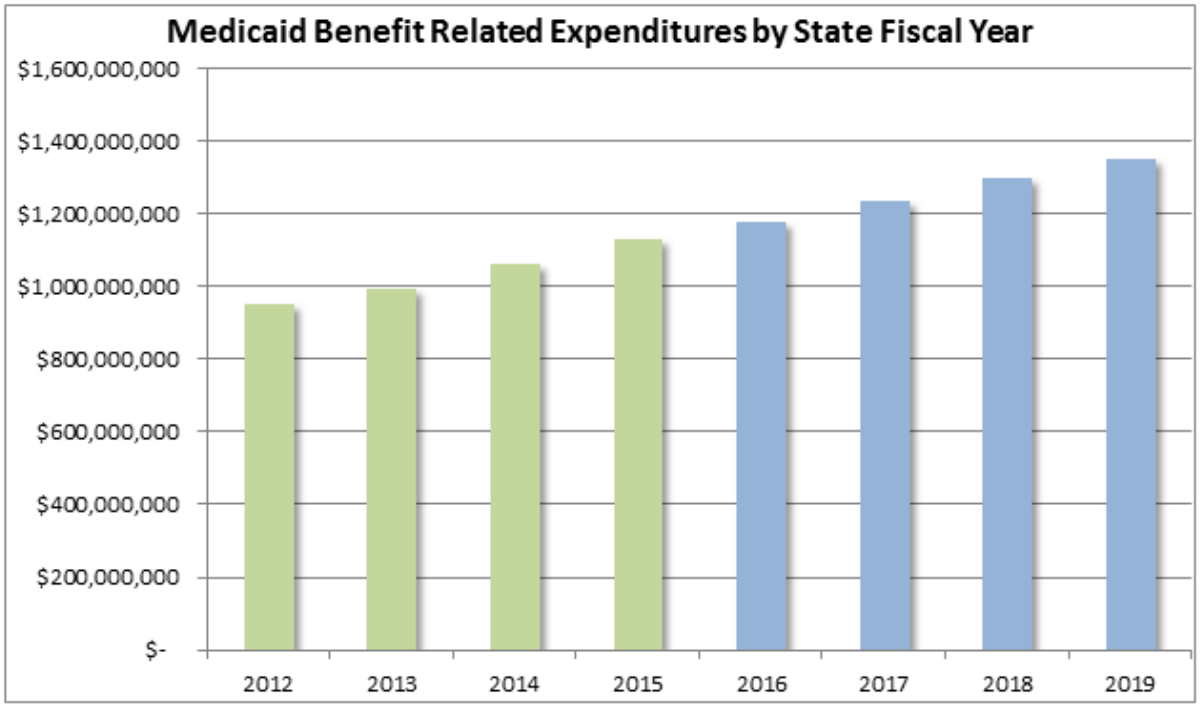


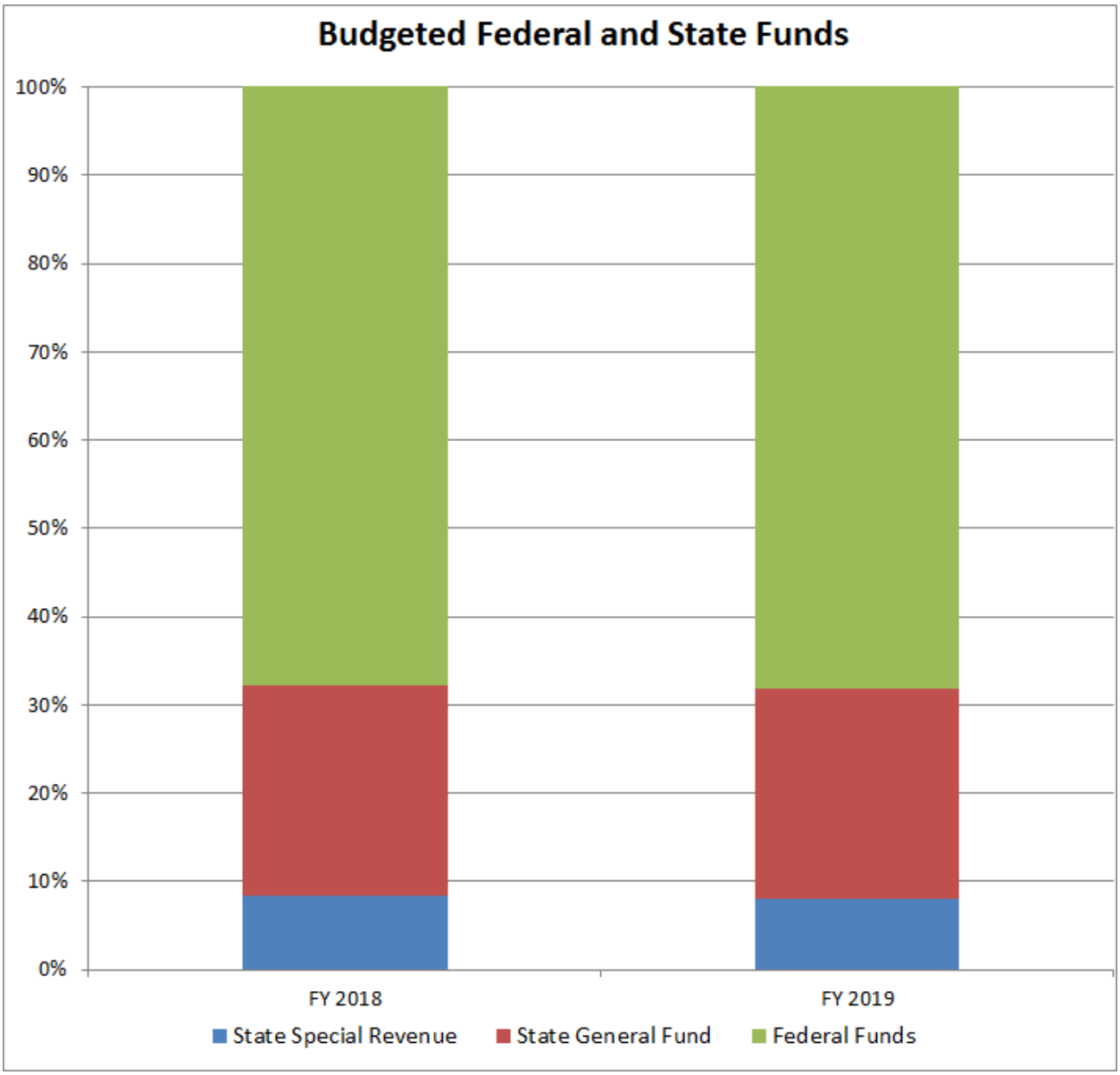
State Fiscal Year	2004	2005	2006	2007	2008	2009	2010	2011
Regular	72.81%	71.96%	70.66%	69.29%	68.59%	68.08%	67.48%	66.86%
Actual / Enhanced	75.36%	71.96%	70.66%	69.29%	68.59%	74.80%	77.65%	74.58%

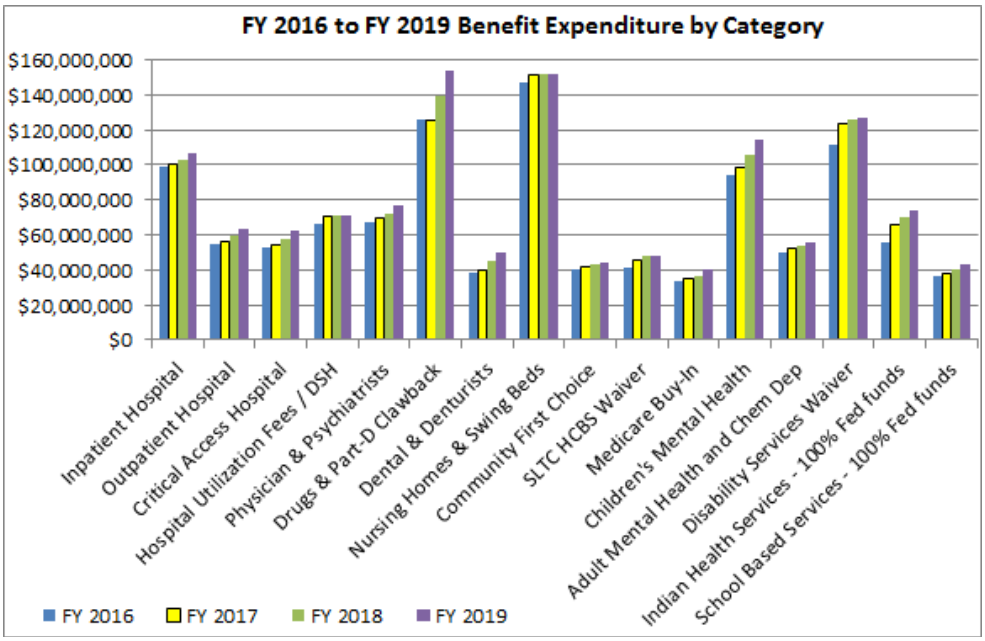
State Fiscal Year	2012	2013	2014	2015	2016	2017	2018	2019
Regular	66.21%	66.04%	66.25%	65.92%	65.30%	64.72%	64.62%	64.62%
Actual / Enhanced	66.21%	66.04%	66.25%	65.92%	65.30%	64.72%	64.62%	64.62%

Montana Medicaid Benefits Related Expenditures

The following series of Medicaid expenditure data only includes benefit related expenditures. It does not include administrative activity costs. Benefit related expenditures for Hospital Utilization Fee distributions, Medicaid Buy-in, Intergovernmental Transfers (IGT), Pharmacy Rebates, Part-D Pharmacy Clawback, and Institutional Reimbursements for Medicaid, Third Party Liability (TPL), and Medically Needy offsets are included. These are non-audited expenditures on a date of service basis. Unless otherwise noted all reimbursement and eligibility data in the report was collected from the month end reports on September 2016. Data for SFYs 2016 to 2019 are the Governor's budgeted amounts and/or estimates.




Budgeted Federal and State Funds
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
FY 2018
FY 2019
State Special Revenue
State General Fund
Federal Funds



	Projected Medicaid Expenditures			
Categories	FY 2016	FY 2017	FY 2018	FY 2019
Inpatient Hospital	$ 98,563,895	$ 100,174,861	$ 102,675,888	$ 106,841,986
Outpatient Hospital	55,127,456	56,075,901	59,196,335	63,442,041
Critical Access Hospital	52,394,916	54,397,902	57,709,805	62,155,680
Hospital Utilization Fees / DSH	66,755,614	70,668,465	70,668,465	70,668,465
Other Hospital and Clinical Services	29,324,373	30,949,969	33,035,541	35,705,072
Physician & Psychiatrists	67,166,574	69,609,090	72,489,952	76,639,036
Other Practitioners	23,591,569	25,447,269	27,252,784	29,447,552
Other Managed Care Services	12,355,079	13,046,821	13,055,006	13,180,550
Drugs & Part-D Clawback	125,488,639	125,667,881	139,382,939	153,698,296
Drug Rebates	(68,080,561)	(65,447,642)	(71,609,344)	(78,406,378)
Dental & Denturists	38,450,323	40,331,786	45,036,429	50,330,729
Durable Medical Equipment	15,069,952	15,890,451	16,166,399	16,613,271
Other Acute Services	3,917,294	4,076,848	4,479,168	4,980,273
Nursing Homes & Swing Beds	147,486,958	151,235,265	151,633,138	152,050,547
Nursing Home IGT	12,527,238	14,150,700	20,150,700	20,150,700
Community First Choice	40,205,130	41,746,728	43,059,170	44,413,672
Other SLTC Home Based Services	8,988,071	10,647,972	11,187,347	11,807,437
SLTC HCBS Waiver	41,534,392	45,509,629	48,104,100	48,104,100
Medicare Buy-In	33,275,829	35,272,379	36,778,653	40,371,021
Children's Mental Health	94,362,209	98,408,357	105,738,599	114,440,816
Adult Mental Health and Chem Dep	49,865,461	52,403,638	53,935,546	56,205,778
HIFA Waiver	18,351,332	9,300,128	9,207,127	9,207,127
Disability Services Waiver	111,784,498	123,209,551	125,888,484	126,574,538
Indian Health Services - 100% Fed funds	55,594,805	66,232,379	69,837,196	73,623,065
School Based Services - 100% Fed funds	36,227,258	38,283,227	40,195,270	42,894,868
MDC & ICF Facilities - 100% Fed funds	11,512,162	12,169,821	12,418,646	5,486,608
Total	$ 1,181,840,466	$ 1,239,459,374	$ 1,297,673,341	$ 1,350,626,850

Chronology of Major Events in Medicaid

2016 - On April 29, 2015, Governor Steve Bullock signed the bipartisan Health and Economic Livelihood Partnership (HELP) Act into law. Coverage began January 1, 2016. Prior to the HELP Act, Medicaid health coverage was limited to children, pregnant women, very poor parents of children (under 54% of the FPL), the elderly, and people with disabilities. Now, coverage is available to adults who are between the ages of 19-64 with incomes at or below 138% of FPL, or roughly $1,350 a month for one person, and $2,300 a month for a family of three. The HELP Act also included significant provisions related to personal responsibility and workforce development. Montana was the first state in the country to expand Medicaid using a private Third Party Administrator (TPA) and only the 7th to incorporate personal responsibility provisions such as copays and premiums.

2016 - In 2016, DPHHS entered into an agreement with the Confederated Salish and Kootenai Tribes that allows the Tribes to determine Medicaid eligibility on the Flathead Indian Reservation. The Chippewa Cree Tribe has had a similar agreement in place for several years. Tribal members can now apply for services locally and barriers and delays are often reduced that may impede tribal members from obtaining Medicaid benefits and proper medical care.

2016 - Service First, a de-centralized task-based Medicaid eligibility system, was fully implemented across the state. This new "cloud-based" system increases the efficiency of workers and decreases the processing time for Medicaid eligibility determinations.

2015 - CMS approved a new state plan amendment that substantially increases reimbursement for tribally owned nursing facilities. This re-financing initiative makes the nursing homes eligible for 100% federal match for the majority of their patients. Revenue to each Tribe is increased by approximately $1 million/year and savings to the state general fund are in excess of $600,000/year.

2014 - The Patient-Centered Medical Home model of care, implemented in December 2014, is designed to provide medical members with a comprehensive, coordinated approach to primary care. PCPs receive additional reimbursement for each panel member enrolled for providing enhanced services and a supported infrastructure. The Department has offered contracts to 5 providers to test the efficiency of the program. If all providers participate, over 8800 members will be served.

2014 - HCBS Settings Regulations were issued by the CMS on March 17, 2014 defining permissible Home and Community Based settings. These regulations require states to submit a "transition plan" of how the State proposes to comply with the new settings requirements. The transition plan was submitted to CMS in December of 2014.

2014 - HIFA waiver amendment was submitted June 30, 2014, to include up to 6000 individuals previously eligible for the state-funded Mental Health Services Plan.

2013 - Montana is the fourth state to have a CFC state plan approved by CMS to implement the CFC option, of Section 2401 of the Affordable Care Act and Section 1915(k) of the Social Security Act. Montana's Medicaid SPA adding CFC services was approved on July 8, 2014, with a retroactive effective date of October 1, 2013. The incentive to adopt this option is a permanent 6% increase in the federal share of Medicaid's cost (the FMAP Rate) for CFC services.

2012 - Montana was awarded a MFP demonstration grant from CMS to augment existing Montana's community-based long term services and supports, and to increase HCBS. The grant provides a temporary increase in the federal share of the Medicaid matching rate to pay for services to people who are already receiving Medicaid funded care in an institutional setting and choose to move into certain types of community settings. All waiver and demonstration services receive an enhanced FMAP rate for Medicaid benefits for a period of 365 days of service. At day 366, a participant is served under their qualified waiver at their regular FMAP. Grant funding was awarded effective 9/27/12 through 3/31/16. The transition time has been extended through 12/31/17 with services continuing through 2019.

2011 - An across-the-board provider rate reduction was implemented in order to comply with 17-7-140 of the Montana Code Annotated which requires a certain ending fund balance.

2011 - The Program for All Inclusive Care for the Elderly, originally adopted in 2009, was eliminated by the Montana Legislature as part of the 17-7-111 5% reduction proposals. The PACE program transitioned its last person into other community alternatives and was discontinued on June 30, 2011.

2010 - Provider rate increases were funded with one time only funds.

2010 - The HIFA Waiver was approved by CMS, effective December 1, 2010. CMS approved the addition of 800 individuals who qualified the state funded Mental Health Services Plan and are at least 18 years of age and no older than 64.

2009 - The Disabilities Services Division was renamed the Developmental Services Division and includes Children's Mental Health, the Developmental Disabilities Program, and Montana Developmental Center.

2009 - On January 1, the Developmental Disabilities Program received approval from CMS for the Children's Autism Waiver. Within the year, 50 children were selected and services were implemented.

2009 - On October 1, 2008 a new program was implemented to serve elderly Montanan's in a community setting. The Program for All Inclusive Care for the Elderly is a capitated managed care model that offers a comprehensive service delivery system and integrated Medicare and Medicaid funding. This program is exclusively for individuals 55 and older who live in Yellowstone County or Livingston and meet nursing facility level of care.

2008 - The 2007 Legislature provided Medicaid funding to provide a rate increase when health insurance is provided for direct care workers in the personal assistance and private duty nursing program. The 2009 Legislature annualized these funds in the Health Care for Health Care Worker program to cover the cost of premiums for health insurance that meets defined benchmark criteria.

2008 - In fiscal year 2008 the department began claiming 100% federal match for tribal entities providing Medicaid funded personal assistance services. Currently the Blackfeet, Rocky Boy and Fort Belknap Reservations provide personal assistance services that are reimbursed at 100% federal match.

2008 - The Medicaid Administrative Match (MAM) is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, contracted Montana Tribes are able to be reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal MAM Cost Allocation Plan will give Tribes a mechanism to seek reimbursement for the Medicaid administrative activities the Montana Tribes now perform.

2008 - The Hospital & Clinic program implemented the APR-DRG payment system and changed the ACS pricing methodology. On October 1, 2008, Montana Medicaid implemented a new inpatient reimbursement methodology for all hospitals, which is based on "All Patient Refined Diagnosis Related Groups" (APR-DRGs). In-state CAHs will continue to be paid percent of charges using their cost-to-charge ratio. All other hospitals will be paid a prospective APR-DRG payment that reflects the cost of hospital resources used to treat similar cases.

2008 - On July 1, 2008 the Department submitted a Medicaid family planning waiver to the CMS for approval. Upon approval from CMS family planning services are anticipated to be provided to about 4,000 low-income women of child bearing age beginning in July 2009. The waiver will decrease the number of unintended pregnancies, improve the overall health of enrollees, and save money for the Montana Medicaid program.

2008 - In June of 2008 a pared down Health Insurance Flexibility and Accountability (HIFA) waiver was resubmitted to the CMS for their consideration. The targeted uninsured (those without physical health care coverage) populations to be assisted with Medicaid benefits were refocused to include 1,600 individuals receiving limited mental health benefits through Mental Health Services Plan, 200 youth with a Serious Emotional Disturbance that had aged out of the Montana Foster Care system, and 150 individuals to be assisted with the costs of affordable health care coverage through their ability to participate in the Montana Comprehensive Health Association Premium Assistance Plan.

2008 - Increased the base wage rates for direct-care staff providing services to consumers with developmental disabilities and raised direct-care wages to at least $9.50 an hour.

2008 - The 2007 Legislature increased direct care worker wage to a minimum of $8.50 per hour, but in addition in SLTCD community based services was raised to $9.35 per hour and nursing homes to $9.20 per hour for certified nurse aides and personal care attendants. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2007 - Nursing facility provider tax was increased by $1.25 from $7.05 to $8.30 per day to fund nursing facility rates and services.

2007 - The eligibility requirements for pregnant women increased from 133% to 150% of the federal poverty level by legislative action.

2007 - The 2007 Legislature increased health-care provider rates, the increases vary across services and provider types, from a low of 1.39% to a high of 4.26%. The increases for SFY2007 generally began in October 2007 and the SFY2008 increases generally began in July 2008.

2007 - HCBS waiver for adults age 18 and over with severe disabling mental illness (SDMI), who without the waiver would be in nursing homes, was implemented. The SDMI waiver is available in certain core areas of the state and the surrounding counties. The waiver team in each core area consists of a nurse and a social worker who coordinates services provided to the covered individuals.

2007 - Executed an agreement with the Chippewa Cree Tribe to facilitate the provision of Medicaid benefits to reservation residents. The agreement enables the Tribe to make Medicaid eligibility determinations on the reservation, reducing barriers or delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

2006 - Medicare Modernization Act implemented the Medicare Part D drug program that applied to approximately 16,000 Montanans who were eligible for both Medicare and Medicaid (dual eligibles). With the implementation of the Act, the dual eligibles will no longer receive prescription drug coverage through Medicaid, instead their prescription drugs are covered by a Medicare Part D plan. The Department is mandated to pay a portion of the drug cost through a Phased-Down Contribution (clawback) for dual eligible clients enrolled in Medicare Part D. Medicaid continues to cover barbiturates, benzodiazepines, smoking cessation drugs, prescription vitamins and the over-the-counter drugs for the dual eligibles as allowed in the Medicaid program.

2006 - The amount of assets a family can have and still qualify for children's Medicaid increased from $3,000 to $15,000 as a result of 2005 Montana Legislative action. Families must continue to meet income requirements to be eligible for children's Medicaid.

2006 - The most recent amendment to the Developmentally Disabled Waiver occurred. The waiver serves people with significant support needs and the amendment expanded service options to include adult foster support, community transition services, adult companionship, assisted living and residential training support.

2006 - The Health Insurance Flexibility and Accountability (HIFA) waiver was submitted to CMS. The Waiver is intended to create a mechanism for Medicaid to pay for services that have historically been funded entirely with state dollars. This will allow the freed up state dollars to leverage additional Medicaid federal dollars.

2006 - The Deficit Reduction Act of 2005 (DRA) mandated certain Medicaid eligibility changes for people who are going to be institutionalized, reside in a nursing home or who are on a waiting list for a Waiver opening. The DRA eligibility changes include increasing the penalty look-back period from three years to five years for nursing home benefits for individuals who transfer assets at less than fair market value, with the look-back period changed to begin when the individual becomes eligible for Medicaid; new citizenship and identity verification requirements of applications for Medicaid; annuities owned by an ineligible or community spouse are considered countable resources for Medicaid applicants; the unpaid balance of a promissory note is considered a countable resource for Medicaid applicants; and the establishment of a $500,000 home equity exclusion limit for long term care applicants/recipients.

2006 - Direct care worker wage increase of $1.00 per hour for nursing facilities and community service providers were implemented utilizing I-149 funding. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children's Mental Health Bureau.

2006 - Implemented a 3% provider rate increase to nursing facilities and community service providers utilizing I-149 funding.

2006 - Nursing facility provider tax was increased by $1.75 from $5.30 to $7.05 to fund nursing facility provider rates and services.

2005 - As a result of the Montana Health Care Redesign Project the 2005 Montana Legislature authorized DPHHS to revise the asset test used to determine children's eligibility for Medicaid and the submission of a Health Insurance Flexibility and Accountability (HIFA) Waiver.

2005 - Montana joined the National Medicaid Pooling Initiative (NMPI) in implementing a Preferred Drug List (PDL). The pooling initiative included seven other states: Nevada, Michigan, Vermont, New Hampshire, Alaska, Minnesota and Hawaii and will be implemented through a contract with First Health Services Corporation (FHSC). Under the initiative, the state Medicaid program will create a list of preferred medications in 50 classes of drugs. Preferred drugs are chosen based on their clinical efficiency by a committee of Montana physicians and pharmacists and by the Department based on cost savings. By contracting with FHSC, Montana was able to combine our 80,000 covered lives with covered lives of the other NMPI states resulting in over 3,000,000 covered lives which allow our contractor to negotiate lower discounts with Pharmaceutical Manufacturers.

2005 - The first five year renewal of the Developmental Disabilities Community Supports Waiver occurred. The waiver offers a number of innovative and flexible service options for persons with limited support needs.

2005 - Nursing facility provider tax was increased from $4.50 to $5.30 to fund nursing facility provider rates.

2004 - Team Care program was implemented targeted to people who over-use the Medicaid system. The program requires a group of identified Medicaid clients to enroll in the program and choose one primary care provider and one pharmacy to manage their health care. Clients will receive the professional care they need and have a team to help them decide how and when to access care.

2004 - Montana Health Care Redesign Project Report was published. The Project resulted from 2003 Montana Legislative action and was intended to examine the various options for redesigning the Montana Medicaid program. The Report was provided to the 2005 Legislature outlining the options that could be undertaken to redesign the identified health programs in a fashion that was financially sustainable into the future.

2004 - Nurse First Care Management program was implemented to reduce ineffective use of medical services. Key components are a Nurse Advice Line for most individuals on Medicaid and a Disease Management program for those with chronic conditions such as asthma, diabetes and congestive heart failure.

2004 - FAIM Basic Medicaid waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under - Sections 1925 or 1931 of the Social Security Act.

2004 - Hospital tax was implemented. This change provided increased reimbursement to hospitals using a state tax on hospitals matched with federal Medicaid dollars.

2004 - Nursing facility provider tax increased from $2.80 to $4.50 to fund nursing facility provider rates.

2003 - Children's Mental Health Bureau was created in the Health Resources Division.

2003 - Eliminated coverage of gastric bypass surgery and routine circumcisions at the recommendation of the Medicaid Coverage Review Panel composed of Montana physicians.

2003 - Child and Family Services Division began billing Medicaid for targeted case management services provided to children at risk of abuse and neglect.

2003 - Outpatient reimbursement methodology was changed to Ambulatory Payment Classification.

2003 - On January 10, 2003 implemented a 7% net pay reduction to providers (sunset June 30, 2003).

2003 - On February 1, 2003 reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system (sunset June 30, 2003).

2003 - On August 1, 2003, reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system. Changed all interim reimbursement rates for cost-based facilities to the hospital specific cost to charge ratio.

2002 - Increase cost sharing requirements for which the Medicaid eligible persons are responsible.

2002 - Began covering outpatient chemical dependency for adults.

2002 - Implemented a 2.6% net pay reduction to providers (sunset June 30, 2002).

2002 - Implemented reimbursement reductions to hospital inpatient services by reducing the base rates, decreasing the DRG weights by 2%, and eliminating the additional catastrophic case payment.

2002 - July 1, 2001 moved to a case mix price-based system of reimbursement for nursing facility providers.

2001 - Implemented a mandatory generic substitutive policy for pharmaceuticals in the outpatient drug program.

2001 - The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment program for low income uninsured women with breast or cervical cancer diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

2001 - Implemented new reimbursement methodology for Ambulance & Dental Services. Included an 18% increase in funding for the dental program.

2000 - Medicaid HMO program was discontinued due to low penetration and high administrative expenses.

2000 - Nursing Facility Intergovernmental Transfers are implemented to save state general fund.

2000 - Hospital Intergovernmental Transfers are implemented.

2000 - Prior Authorization was required in Personal Assistance Services.

1999 - Mental Health Managed Care abandoned per legislative requirement.

1999 - Ambulatory Surgical Center provider reimbursement was restructured to align with Medicare reimbursement methodologies.

1998 - Area Agencies on Aging converted state general fund to buy slots to expand Waiver.

1997 - New MMIS contract was instituted with Consultec as the fiscal agent (Consultec later changed its name to Affiliated Computer Services.

1997 - Resource Based Relative Value System (RBRVS) was implemented to reimburse Physicians, Mid-Level Practitioners and Therapies.

1997 - Mental Health Managed Care was implemented. This program institutes a full-risk, capitated managed care contract for all mental health services statewide.

1997 - Prior authorization was required of Home Health Agency services.

1996 - Federal welfare reform was passed on August 22, 1996. Under the Personal Responsibility and Work Opportunities Reconciliation Act, Medicaid was "de-linked" from AFDC/TANF and began operating without regard to eligibility for cash assistance.

1996 - Departmental reorganization was implemented. Reorganization results in a decentralization of Medicaid; services are managed in divisions primarily responsible for services to specific populations. For example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.

1996 - New outpatient prospective payment system was introduced. The system uses Day Procedure Groups to bundle services at one basic rate.

1995 - Liens and Estates Recovery Program was implemented by the legislature.

1995 - The Families Achieving Independence in Montana, welfare reform waiver, received federal approval. The FAIM program began phasing-in implementation in February 1996. Even though the cash assistance caseload experienced a significant reduction, Medicaid eligibility continued for most of families. Cost savings were due to the reduced package of services under FAIM Basic Medicaid, not because of decreased caseloads.

1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMOs exist.

1993 - Passport to Health program was implemented. The program assigns a primary care case manager provider to each participating Medicaid enrollee as a health care manager and gatekeeper of services. The program has yielded significant savings in subsequent years and maintained quality of care.

1993 - New hospital reimbursement system was implemented. The system features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change results in significant savings in subsequent years.

1993 - Out of state hospital initiative was implemented. This program restricts the use of higher cost out of state hospitals when in state hospitals provide the same services. This initiative results in significant savings in subsequent years.

1993 - Medicaid coverage for inpatient hospital psychiatric services for individuals under 21 was terminated by the legislature. Coverage for residential treatment and treatment in an acute care hospital remains.

1992 - Federal OBRA 89 increased eligibility for pregnant women and children under age 6 to 133% of the FPL. OBRA 89 stipulates that children are eligible for all medically necessary services.

1992 - Federal OBRA 90 was implemented. A major component of this mandate is to increase eligibility for children aged 6 through 18 to 100% of the federal poverty level. This mandate is being phased in through 2002.

1992 - "Residential Psychiatric Services" was implemented as a Medicaid Service. This service brings rapid increases in cost for the next several years.

1992 - Drug Rebate Program was implemented and began to return a significant portion of prescription drug costs to the state in the form of rebates.

1992 - Formulary and Drug Utilization Review Program was implemented for Medicaid pharmacy services. This program provides significant internal controls and cost savings in subsequent years.

1991 - Nursing home provider tax was implemented. This change increased reimbursement to nursing homes using a state tax on nursing homes matched with federal Medicaid dollars.

1990 - Federal OBRA 87 was implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate affects primarily the nursing home industry and increased Medicaid costs through increased reimbursement to providers. OBRA87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children younger than 6 years.

1988 - "Inpatient Psychiatric Services for Children under age 21" became a Medicaid service. This service increased costs rapidly for the next several years.

1987 - New Hospital reimbursement system was instituted. This Diagnosis Related Group (DRG) system is a prospective rate system.

1985 - New MMIS was instituted with Consultec as the fiscal agent.

1983 - Department lost Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1) retroactive payments for prior years; 2) increased reimbursement rates for subsequent years.

1982 - The HCBS waiver was implemented. This program consists of multiple services not traditionally offered to Medicaid recipients and designed to help people stay in their own homes rather than moving to an institution.

1982 - Prospective reimbursement system was instituted for the Nursing Home program.

Glossary of Acronyms

AAC: Average Acquisition Cost

AMDD: Addictive and Mental Disorders Division

APR-DRG: All Patient Refined-Diagnosis Related Grouper (APR-DRG)

BCBSMT: Blue Cross Blue Shield of Montana

CAH: Critical Access Hospitals

CAW: Children's Autism Waiver

CFC: Community First Choice

CMS: Centers for Medicare and Medicaid Services

CSCT: Comprehensive School and Community Treatment

DD: Developmental Disabilities

DPHHS: Department of Public Health and Human Services

DRG: Diagnosis Related Group

DSD: Developmental Services Division

FQHC: Federally Qualified Health Centers

FMAP: Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level

FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is October 1—September 30)

HIFA: Health Insurance Flexibility and Accountability

HCBS: Home and Community Based Services

HELP Act: Health and Economic Livelihood Partnership

HMK: Healthy Montana Kids (Healthy Montana Kids (HMK) is the largest provider of health care coverage for children in the State of Montana. HMK covers children through Medicaid and CHIP funding.

HMK Plus: The Medicaid portion of HMK is referred to as Healthy Montana Kids *Plus.*

IHS: Indian Health Service

IGT: Inter Governmental Transfers

LARC: Long Acting Reversible Contraceptives

LTC: Qualified Long Term Care Partnership

MFCU: (Attorney General's) Medicaid Fraud Control Unit

MFP: Money Follows the Person

MMIS: Medicaid Management Information System

MWD: Montana Medicaid for Workers with Disabilities

OIG: Office of Inspector General

PERM: Payment Error Rate Measurement

PCMH: Patient-Centered Medical Home

PPC: Promising Pregnancy Care

PCP: Primary Care Provider

QI: Qualifying Individual

RAC: Recovery Audit Contractors

RBRVS: Resource-Based Relative Value Scale

RHC: Rural Health Clinic

SDMI: Severe and Disabling Mental Illness

SFY: State Fiscal Year (July 1—June 30)

SLMB: Specified Low-Income Medicare Beneficiary

SMAC: State Maximum Allowable Cost

SSI: Supplemental Security Income

SPA: State Plan Amendment

TPA: Third Party Administrator

TPL: Third Party Liability

QMB: Qualified Medicare Beneficiary